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STATE MEDICAL JOURNAL
VOLUME 19 NUMBER 1
JANUARY 1970

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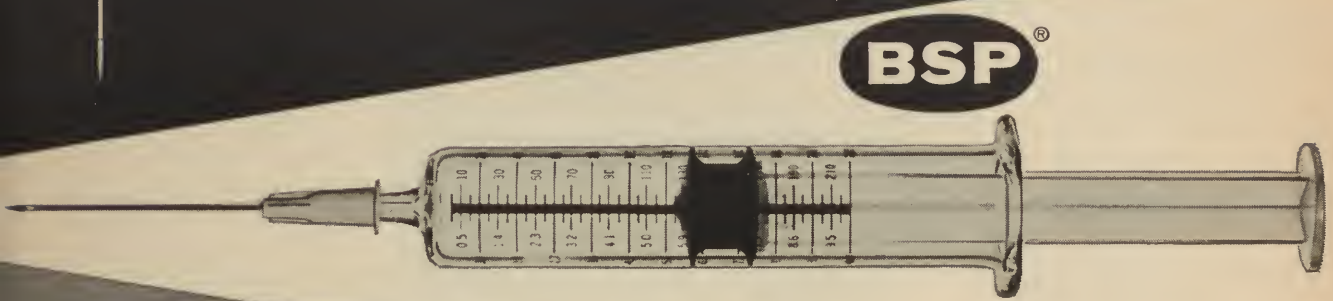
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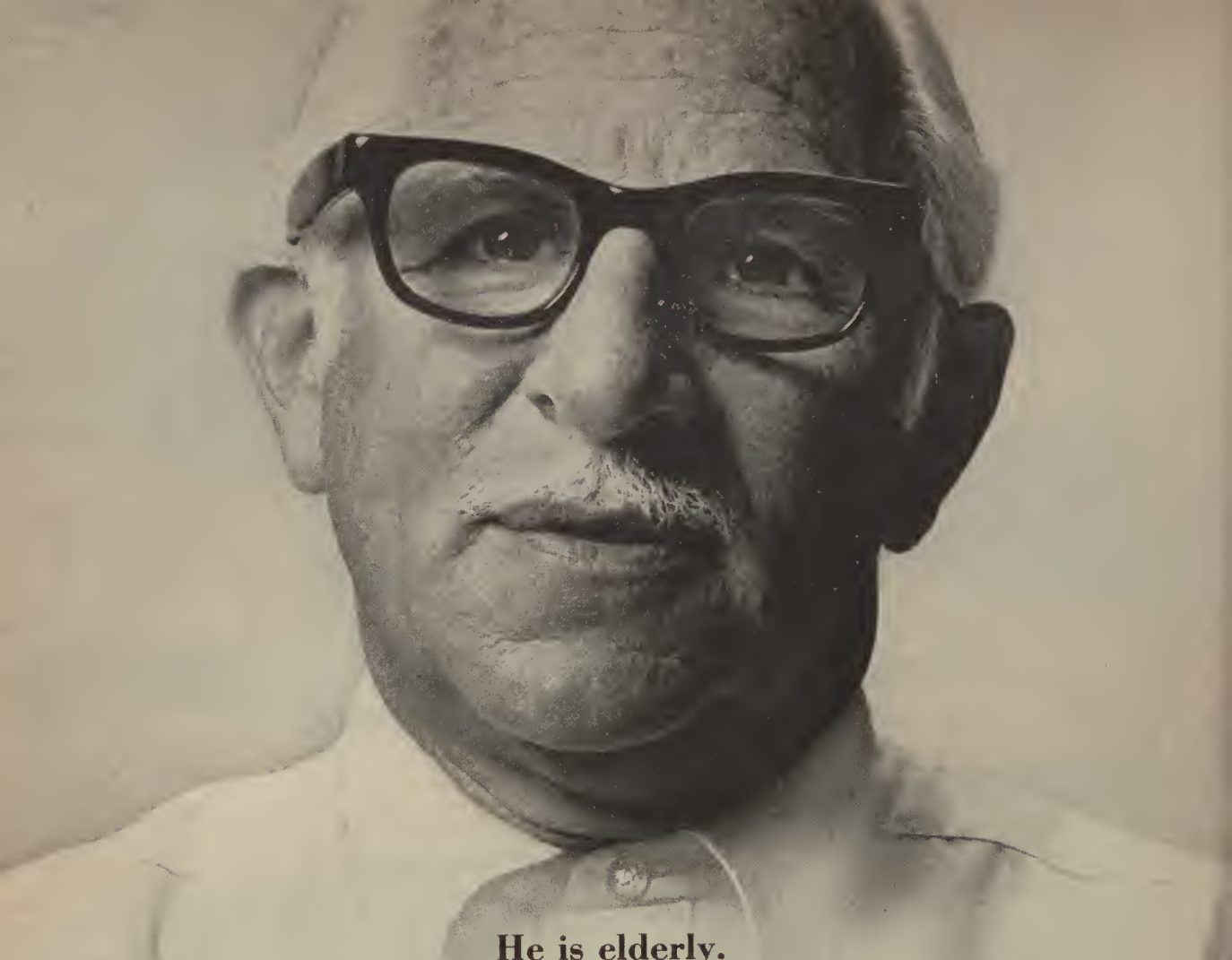
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes: a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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maryland state MEDICAL JOURNAL

VOLUME 19 JANUARY 1970 NUMBER 1

CONTENTS:

Editorial—The Commission on Medical Discipline, John Sargeant . . . 65

Introduction—Legal Aspects of Malpractice Suits As They Affect the Practice of Medicine, Judge George D. Solter, Howard F. Kinnamon, MD 66

Malpractice from the Private Practice and Institutional Psychiatric Viewpoint, John M. Hamilton, MD 69

"There was a time when all of the fears and concerns about physician malpractice could be conveniently stored in the stock phraseology learned by every medical student in a course possibly labeled "Medical Jurisprudence 101." Malpractice has subsequently become a much more complex area of concern."

Perfection of Standards, and Informed Consent in Preventing Malpractice Suits, Paul E. Huffington, MD 75

"To illustrate the impact of medico-legal decisions on the practice of medicine, I can think of no more vivid case than one tried a decade ago in Ireland. The plaintiff was given a spinal anesthetic for surgery. Subsequently, there was temporary residual neurological damage to the bowel and bladder. The plaintiff sued and recovered. Since that case, virtually no spinal anesthesia has been given in Ireland. In Ireland, the anesthesiologist feels that he hasn't a fair chance with the law."

The Implications of Malpractice Suits, B. Martin Middleton, MD 78

"This is an age of progress, an age of hope. It is an exciting time. But, one of the fundamental problems that faces our society today is our inability to put technological advances on a par with human advances, and, as a result, we are faced with the problems of medical malpractice."

Malpractice Implications and the Safeguards in Maryland's Law, Judge W. Albert Menchine 81

"What appears to be a major problem in discussing the issue of malpractice suits against a physician is the question of whether or not the physician is presented with an accurate picture of the law that governs and controls this litigation."

Suits Against Physicians for Professional Negligence from the Defendant's Point of View, John F. King, Esquire 84

"It is the suit that is irreparably damaging to the physician and to this, that is the mere filing, there is absolutely no defense. This defenselessness to injury is one which physicians do not believe the Bar by-and-large fully appreciates."

The Need for Medico-Legal Cooperation in Treating Malpractice Suits, Joseph I. Pines, Esquire 88

"The problems of medical malpractice are deep-rooted. Physicians are of the impression that patients and lawyers do not understand that a bad result does not automatically mean that a malpractice suit is in order. Lawyers are similarly unhappy because they claim that they cannot get the cooperation and assistance from the medical profession which they need to properly represent their clients."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 92

Maryland State Department of Mental Hygiene—Voluntary Admissions 95

Alcoholism—One for the Plant 97

Tuberculosis—The First Breath 101

Baltimore City Health Department—Highlights 103

Maryland State Department of Health—National Registry for Congenital Rubella Syndrome 107

Rehabilitation Notes—History of Treatment of Spinal Cord Injuries—Douglas G. Carroll, MD 109

Heart Page—The Electrocardiogram in Clinical Alterations of Potassium Homeostasis, Part 2, Ralph Weber, MD 113

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

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ON THE COVER: This month's cover is the original work of Z. John Levay, MD, a Baltimore psychiatrist.

—0—

Doctors Take Note **5**

Executive Secretary's Newsletter **9**

Orient Tour **13**

SSA Letter No. 372 **17**

Component Society News **27, 31**

Maryland Association of Medical Assistants **33**

MEDIC **34**

The Month in Washington **37**

Professional Liability Insurance **40**

Informed Consent **45**

Book Reviews **46**

Medical News **51**

Annual Meeting News **57**

Arts and Hobby Exhibit **59**

Annual Meeting Hotel Reservation **60**

Revised Policy—Laboratory Services and Billing **93**

Woman's Auxiliary **105**

Classified Advertising **118**

Advertising Index **119**

Information for Authors **120**

Index to Volume 18, January-December 1969 **121**


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Twenty-fifth Annual Lecture: 11:30 AM, Gordon Wilson Hall, University of Maryland Hospital, Baltimore, Md. Speaker: Dorothy Horstmann, MD, professor of epidemiology and pediatrics, Yale University School of Medicine. Subject: Rubella Vaccine—Problems and Progress. Contact: Ronald Goldner, MD, University of Maryland Hospital, Baltimore, Md. 21201.

JANUARY 20, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Obstructive Disease and Urinary Diversions: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: Earl P. Galleher, MD.

JANUARY 21, 1970
MARYLAND KIDNEY FOUNDATION

Seminar—The Relation of Renal Lymphatics to Function and Disease: 5 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: John J. Murphy, MD, Professor of Urology, University of Pennsylvania School of Medicine.

JANUARY 21, 1970
BALTIMORE CITY AND COUNTY UNITS/AMERICAN CANCER SOCIETY

Head and Neck Cancer Seminar: Turner Auditorium, Johns Hopkins Hospital, Baltimore. The seminar, intended for physicians, dentists, and medical students, will begin with a noon luncheon. Keynote speaker: James Callison, MD, Associate Professor of Plastic Surgery, Johns Hopkins Hospital. For additional information, or tickets for the luncheon, call either the Baltimore City Unit (539-4000) or the County Unit (825-3091) of the American Cancer Society.

JANUARY 26-29, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Practical Approach to Selected Clinical Problems: Ochsner Medical Foundation, New Orleans, La. Director: C. Thorpe Ray, MD, FACP. For further information, contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

JANUARY 27, 1970
NEW YORK HEART ASSOCIATION

Conference—Glomerulonephritis: The Waldorf-Astoria Hotel, Park Avenue and 50th Street, New York, New York. Advance registration is required. Write: New York Heart Association, Inc., 2 East 64th St., New York, New York 10021.

FEBRUARY 2-4, 1970
AMERICAN HEART ASSOCIATION

Three Days of Cardiology—Modern Cardiac Physical Diagnosis: University of Cincinnati Medical Center, Cincinnati, Ohio. For further information, write: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

FEBRUARY 3, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Tissue Typing for Transplantation: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: Robert M. Ollodart, MD.

FEBRUARY 5, 1970
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course—Obstetrics: University of Maryland School of Medicine, Baltimore. Contact: University of Maryland School of Medicine, Committee on Continuing Education, 522 W. Lombard Street, Baltimore, Maryland 21201.

FEBRUARY 11, 1970
UNIVERSITY OF CHICAGO

Postgraduate Course—Abnormal Uterine Bleeding and Pain: University of Chieago, Chicago, Ill. The goal of the presentations is to provide perspectives that will directly aid the clinician who encounters these problems in his practice. Write: Albert B. Lorincz, MD, Professor, Department of Obstetrics and Gynecology, The University of Chicago, Chicago, Ill. 60610.

FEBRUARY 14-18, 1970
THE AMERICAN ACADEMY OF ALLERGY

Annual Meeting and Postgraduate Course—Pulmonary Diseases and Asthma, Developments in Medicine Relating to Allergy, Clinieal Immunology, Organ Transplantation: Jung Hotel, New Orleans, La. For further information, write: the American Academy of Allergy Executive Offiee, 756 North Milwaukee Street, Milwaukee, Wisconsin 53202.

FEBRUARY 17, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—New Approaehes to Immunosuppression: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. Speaker: Robert M. Ollodart, MD.

FEBRUARY 18, 1970
MARYLAND KIDNEY FOUNDATION

Seminar—Toxic Factors in Uremia: 5 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Speaker: Burton D. Cohen, MD, Chief, Metabolism Section, Bronx-Lebanon Hospital.

FEBRUARY 18-20, 1970
LAKELAND GRADUATE MEDICAL ASSEMBLY

Meeting—Frontiers of Medicine 1970: Lakeland, Fla. Co-sponsors: Winter Haven Hospital and Bartow Memorial Hospital. The meeting has been approved by the American Academy of General Practice for 14 hours elective credit; registration fee is $100. Contact: Lakeland Graduate Medical Assembly, P. O. Box 2335, Lakeland, Florida 33830.

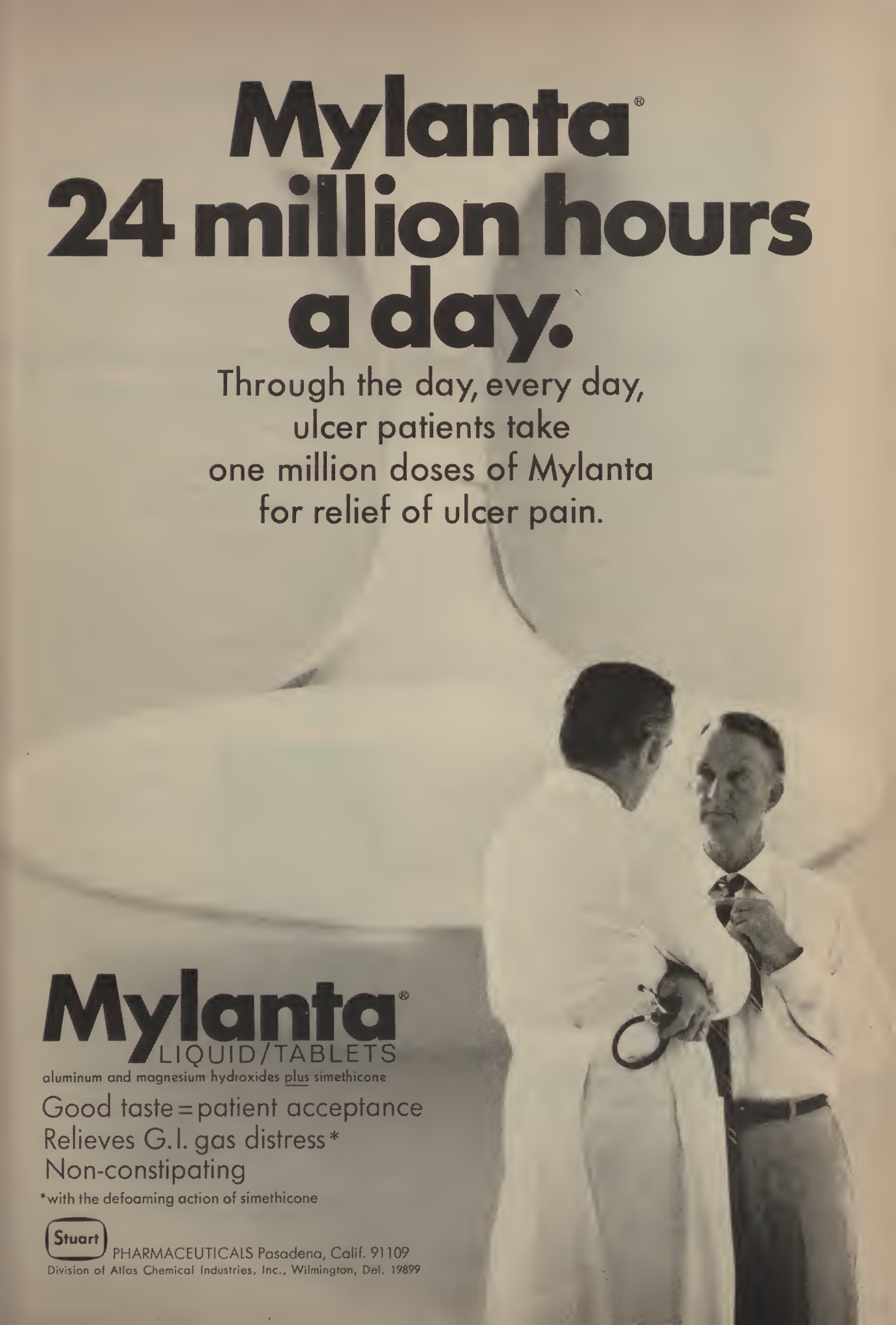
FEBRUARY 23-27, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Modern Gastroenterology for Teachers of Clinical Medicine: University of Michigan Medical Center, Ann Arbor, Mich. Director: H. M. Pollard, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

(Continued on page 29)

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executive secretary's newsletter

January, 1970

DUES BILLS IN MAIL

Dues bills for 1970 have been mailed to all Faculty members. Payment of dues must be received by January 31, 1970 in order for a physician to be eligible for legal defense in the event an action for professional liability is filed against him. A recent Bylaws change by act of special session of the House of Delegates on December 13 clearly spells out this benefit of membership and the provisions that must be met.

Independent panels are selected for the purpose of judging the merits of any legal action for professional liability. In the event a claim is ajudged to be unfounded, expert medical witnesses will be provided for the defendent if the case goes to court.

REORGANIZATION OF NURSING HOME GROUP

The 21-year old Nursing Home Association has been reorganized into the Health Facilities Association of Maryland. The change took place at the organization's annual meeting held in Baltimore on December 8.

The new Health Facilities Association of Maryland embraces all types of health care facilities, including extended care, skilled care, intermediate care; multi-level, non-profit, public and chain-operated facilities.

William R. Greco, MD, of Prince George's County, has been named Treasurer of the group.

PHYSICIANS NOW ELIGIBLE FOR SOCIAL SECURITY BENEFITS

Physicians, who were placed under the Social Security system in 1965, have now contributed to the system long enough to be eligible for some benefits.

While the maximum amount self-employed persons pay into the system has increased from $259.20 in 1965, to $538.20 in 1969; benefits also have been increased over the same period.

COMMITTEE ACTIVITY CONTINUES

As 1969 drew to a close, the Faculty's Committee on Emotional Health continued its investigation into the problems involved in the lack of psychiatric facilities for emotionally disturbed children; transportation of

COMMITTEE ACTIVITY CONTINUES (cont'd)

psychiatric patients to mental institutions; and the treatment of emotional ills of individuals over age 18 without parental consent.

During a recent visit to Baltimore, Joseph Baker, MD, of the AMA's Council on Mental Health, commented that Maryland has well-developed programs (and is much further ahead than most states) in the fields of alcoholism control and drug abuse treatment.

The new Pre-School Hearing and Vision Screening Board has been established. Physicians on the board include Karl M. Green, Cyrus L. Blanchard, Richard E. Hoover, Arnall Patz and Margaret L. Sherrard. Other board members are Miss Harriet Haskins and Mrs. Mary Jane Ellen.

The Board will supervise pre-school vision and hearing screening of four year olds.

The Faculty's Annual Sportsmedicine Seminar was held early in December at the Catonsville Community College. The program, attended by over 200 persons, received considerable publicity including a full-page layout in the Catonsville Times devoted to the presentations of the speakers. The event was cosponsored by the Athletic Department of the community college.

The college is presently offering a noncredit course on the Prevention and Care of Athletic Injuries. The curriculum has been approved by the Faculty.

Be on the lookout for the first issue of The Assemblyman, the legislative newsletter of the Faculty. The General Assembly convenes on January 21, 1970, for it its regular 70-day session. Since 1970 is an election year, it is not anticipated that many controversial pieces of legislature will be adopted.

The Faculty's committee on Postgraduate Education, Preventive Medicine and Public Health conducted a symposium on viral diseases in November. Nearly 200 people attended the event held in Osler Hall.

Be on the lookout next month for a summary of Maryland's Medicaid program, payment basis and other pertinent information.

John Sargeant
Executive Secretary

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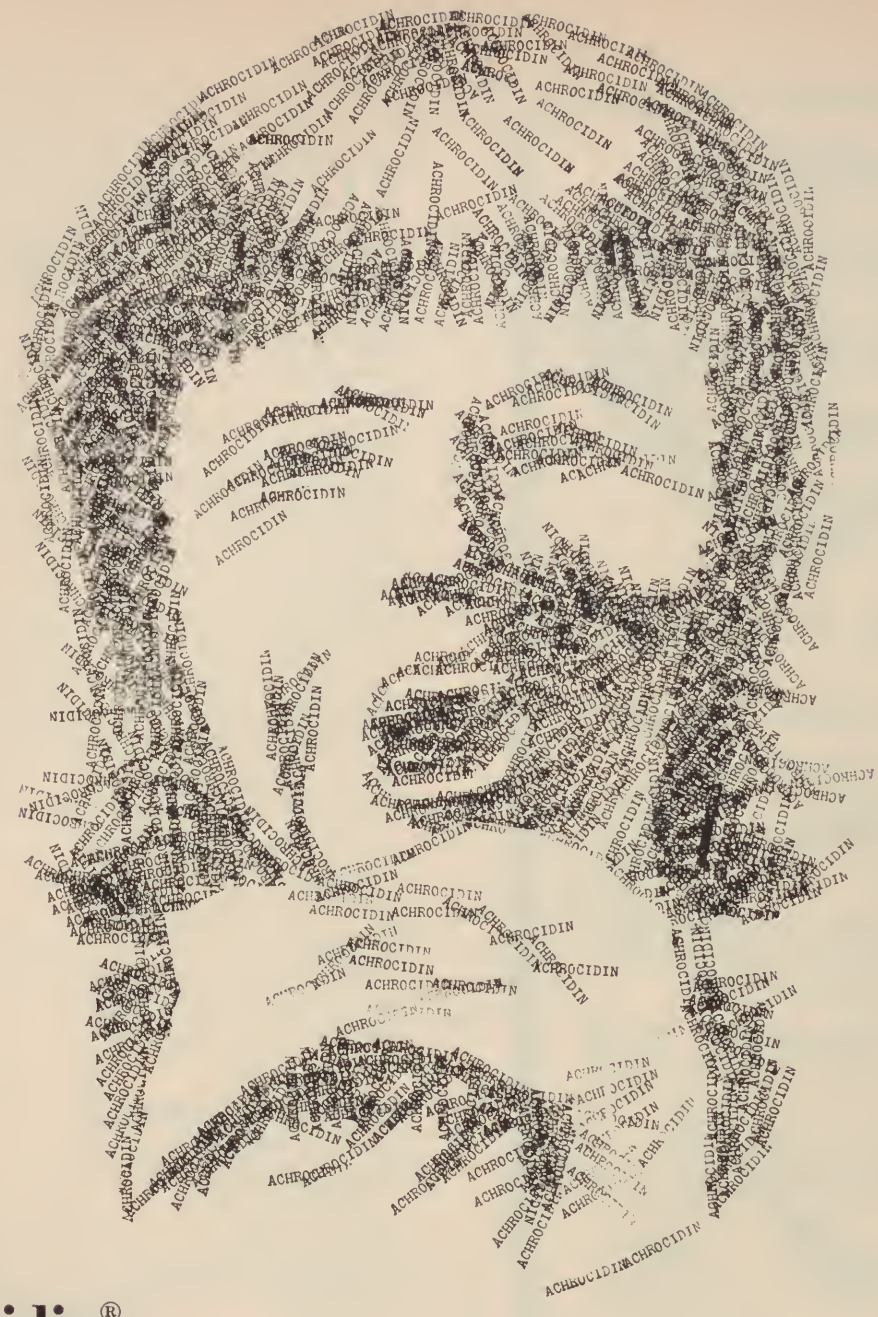
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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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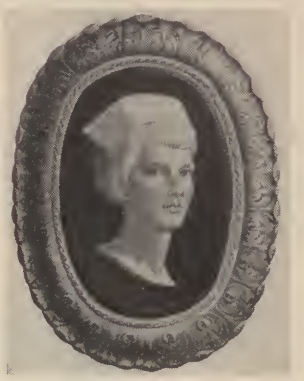
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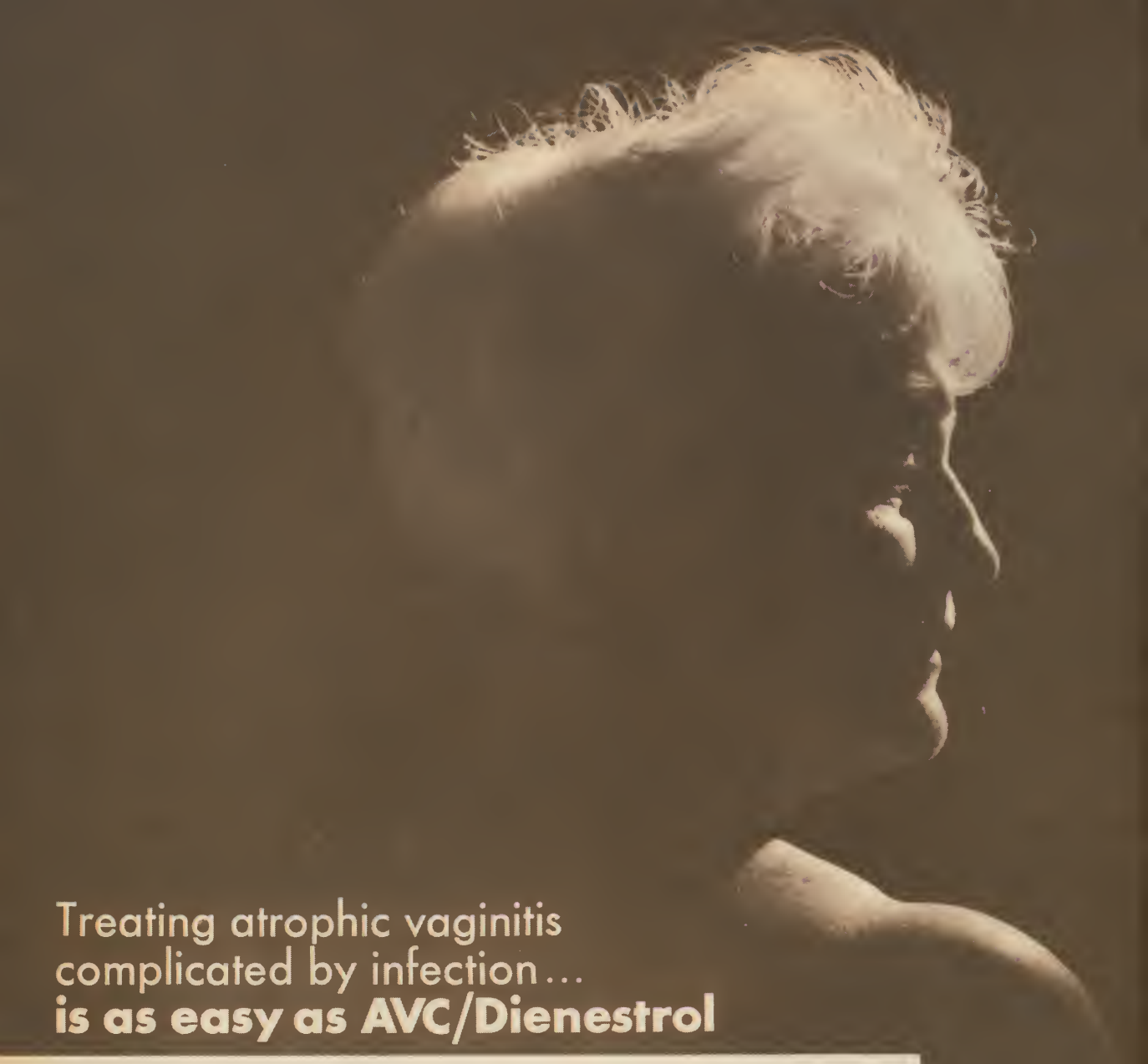
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity or sensitivity are reasons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for careful diagnostic measures to eliminate the possibility of neoplasia of the vulva or vagina. Manifestations of excessive estrogenic stimulation through dienestrol absorption may occur. These include uterine bleeding, breast tenderness, exacerbation of menstrual irregularity and provocation of serious bleeding in women sterilized because of endometriosis. Endometrial withdrawal bleeding may occur if use is suddenly discontinued.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: 'AVC/Dienestrol Cream'—Four ounce tube *with* applicator. 'AVC' and 'AVC/Dienestrol Suppositories'—Box of 12 *with* applicator.

References: (1) Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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SSA Letter No. 372 Affects Residency Training

The publication of Intermediary Letter #372 by the Bureau of Health Insurance of the Social Security Administration pertaining to Part B Payments for services of supervising physicians in a teaching setting has created great concern, particularly among those responsible for residency training programs.

On June 17, 1969, Dr. C. Rollins Hanlon, Director-Elect of the American College of Surgeons, arranged a preliminary meeting with Mr. Arthur Ness, Deputy Commissioner of the Social Security Administration, Mr. Thomas N. Tierney, Director of the Bureau of Health Insurance of the SSA, and Mr. Robert G. Hoyer, Chief of the Health Services Branch, Division of Policy and Standards of the Bureau of Health Insurance. At this meeting, Dr. Hanlon expressed the deep concern of ACS regarding the impact of this directive on surgical training programs, with particular emphasis on the probable decrease in opportunities for senior resident responsibility.

As a result of this initial meeting, Dr. Hanlon, and Dr. Robert M. Zollinger, Chairman of the Surgical Services Committee, were invited to attend a meeting of consultants at the Social Security Headquarters in Baltimore on July 10, 1969. This meeting was called "to obtain a better and more uniform understanding among carriers, providers and physicians of the conditions under which payment may be made under Part B for services rendered to patients by supervising physicians in the teaching setting and the method for determining the reasonable charge which may be recognized for such services."

In addition to the representatives from ACS, there was a broad spectrum of representation from the American health community, including the medical assistance programs, group health insurance programs, the American Hospital Association, and others.

The officials of the SSA expressed the deep concern of Congress regarding problems which had

(Continued next page)

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arisen with the Medicare program, particularly the excessive costs reported from some hospitals in a teaching setting. Special attention was directed to the problems of establishing and administering these federally-assisted health programs in large city hospitals, which traditionally have been concerned with the care of indigent patients.

It has been difficult to develop a single policy embracing both community hospitals, where there is practically no intern or resident staff, and large medical centers, where much of the medical care for all patients is effected by interns and residents in training. The medical center hospitals, "in a teaching setting," constitute a relatively small proportion of the total number of hospitals; nevertheless, they provided much of the health care offered to indigent patients until Titles 18 and 19 of the amended Social Security Act of 1965 were signed into law.

Particular concern was expressed as to how Part B payments might be made "in a teaching setting" when the staff physicians supervising the care of private as well as indigent patients were already salaried by the hospital or university for their administrative and teaching responsibilities, which include supervising the work of the resident staff. There was no widespread recognition of the distinction between staff physicians salaried by a hospital and those salaried by a medical school independent of their patient-care activities in a hospital.

During the interchange of ideas, it became abundantly clear that there is a wide variety of methods used by teaching services in complying with the concept of "supervision"; and all such approaches were freely discussed by those present. There is NO question regarding payment if the surgeon treats the patient as a private patient, performs the operation himself, and carries out all the usual functions connected with preoperative, postoperative and follow-up care. The question on which a decision remains to be made is: Will it be possible to make charges under Part B for patients operated upon by a resident in training, even in the presence of the supervising staff physician, as it has been in the past, if the guidelines published on February 8, 1967, in the *Federal Register** are conscientiously observed?

We anticipate that by the time this report is published, new and different requirements may be in effect. The recurrent theme of "double payment" under Part A for services of those in training, and under Part B for services of those supervising the training, may be altered by changes or reinterpretation of existing legislation. However, it is essential that all chiefs of service as well as the junior and senior members of their staffs be thoroughly familiar with Intermediary Letter #372. The necessity of detailed notations in the chart preoperatively, postoperatively and when the patient is discharged must be emphasized.

It is hoped that additional meetings will be held between representatives of the Social Security Administration and the American College of Surgeons. These challenging problems do not permit an easy interpretation or solution. Any decision which involves federally-supported insurance programs could shortly involve various forms of commercial insurance, and this could leave our residency training programs deficient in opportunities to provide residents senior responsibility. The continuing obligation of the American College of Surgeons is to ensure high quality surgical care for the American public. This must rest on the assurance that educational programs for surgeons will include operative experience adequate in amount, high in quality and with sufficient autonomy for maturing surgeons to permit the development of sound surgical judgment by the time they enter the independent practice of surgery.

*For a copy of the relevant section of the *Federal Register,* Vol. 32, No. 26, February 8, 1967, and Intermediary Letter #372, write to Surgical Services Committee, American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611.

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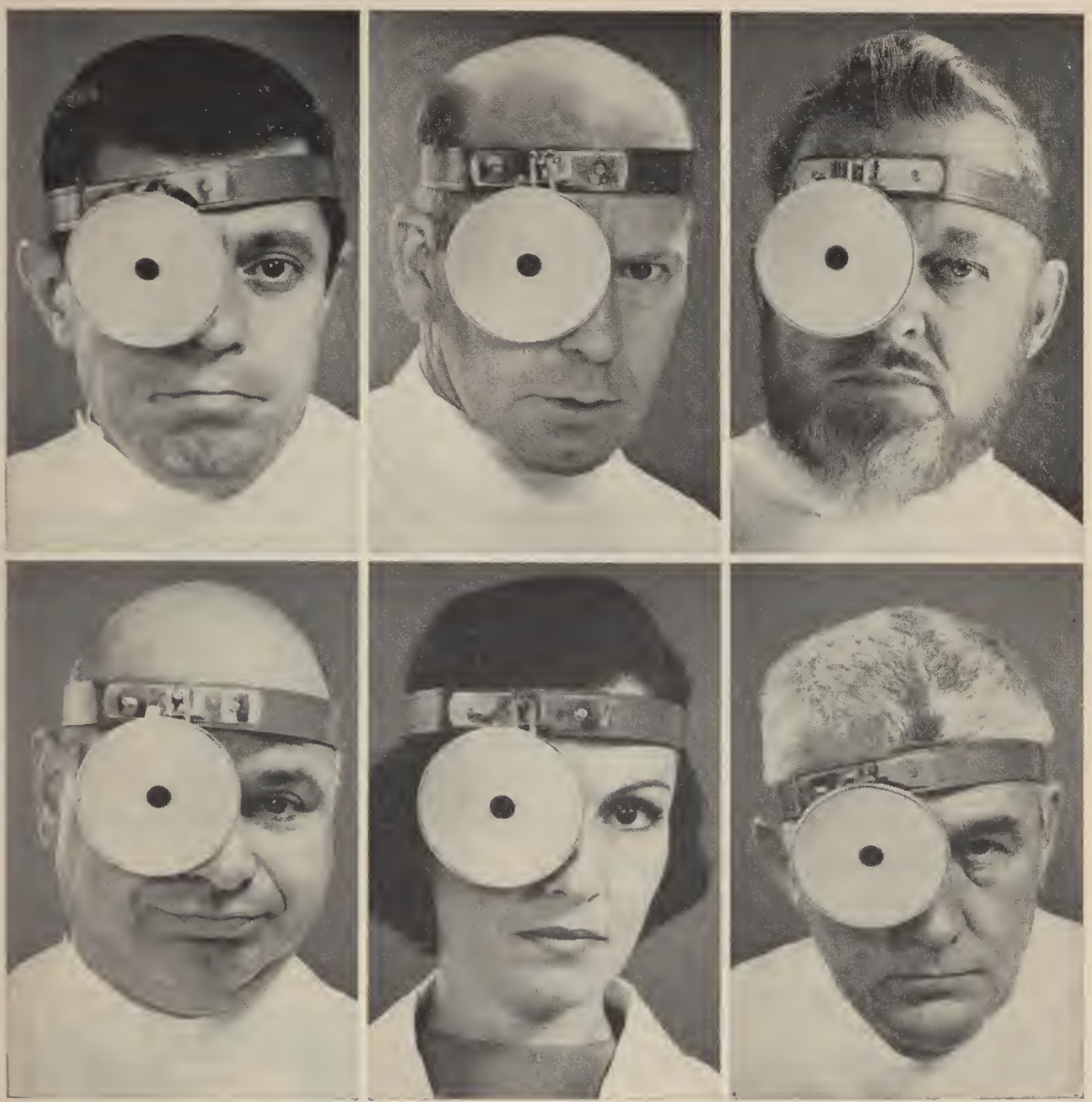
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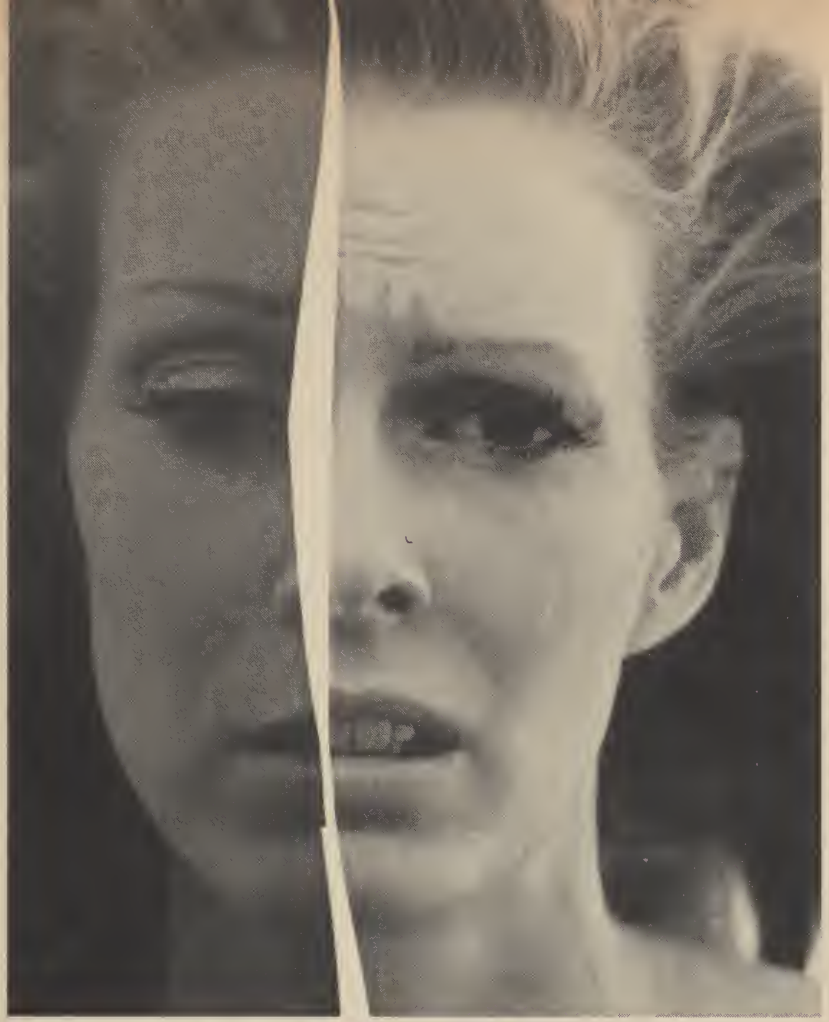
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Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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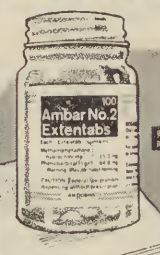


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ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Meeting Notes

The Board of Directors of the Baltimore City Medical Society met at 4:30 PM on November 4, 1969, at 1211 Cathedral Street, Baltimore, Maryland. The meeting was called to order by Raymond C. V. Robinson, MD, President.

The minutes of the October 14, 1969 meeting were read and approved.

The problem of acceptance and support of the proposals put forth by the "Man Alive Program" for the maintenance of addicts on methadone while in the city jail was again considered. It was decided that since the State Medical Society is presently considering the problem of methadone treatment, and the Federal Narcotics Bureau is formulating guidelines for such programs as "Man Alive," it would be premature for the City Society to make any further statement on this matter.

The Board agreed to purchase a caduceus emblem for the new Health Sciences building at the Community College of Baltimore. This will be placed on the outside of the building and carry a placard designating the origin of the gift.

A proposal was approved that the members of the Board each serve a three-month term on the Professional Relations Committee, and as chairman the third month.

Dates for the 1970 Board meetings were presented and approved. These meetings will be held the second Tuesday of each month, except during June and December when the meetings will be held the first Tuesday.

Old business included the continued discussion of a professional relations problem concerning two physicians who recently dissolved an association. The problem presented to the Board concerned ownership of patient records. The Board decided that the physicians involved should discuss the legal questions concerning the association with their respective attorneys and that the Board would rule only on the problems of ethics.

Vincent R. Blake, MD, joined the meeting at this time and informed those present of a proposal for a comprehensive medical care plan being formulated by "MUND" (Model Urban Neighborhood Development). This proposal would provide medical care for residents in the MUND area (located around Greenmount Avenue and 25th Street) on a prepay basis. This will affect the practicing physicians in the area and it was surprising to members of the Board that no knowledge of this program was available until this date.

At the same time, the Board discussed the present Hopkins' Plan for prepaid comprehensive medical care. This plan has been submitted to the Federal Government for funding and was never presented to the Society.

After much discussion, it was agreed that the Society must become more involved in the problems of the practicing physicians in the inner-city, and in order to do this, must be informed of the proposals being made by groups such as MUND and Hopkins. It was suggested and approved that a proposal be made at the next general meeting of the Society which would amend the Bylaws so as to allow the Commissionner of Health of Baltimore city to be a conference member of the Board of Directors. It is hoped that by having the Commissioner attend the meetings of the Board, the Society will be kept aware of plans as they are being developed and the Health Department will know the feelings of the practicing physician as voiced through the Society.

There was no further business, and the meeting was adjourned at 6:30 PM.



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(Continued from page 6)

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19th Annual Scientific Session: Rivergate Center, New Orleans, La. The session will include major scientific symposia and a special group of panel discussions. For additional information, contact: William D. Nelligan, Executive Director, 9650 Rockville Pike, Bethesda, Md. 20014.

FEBRUARY 28, 1970
SOUTH BALTIMORE GENERAL HOSPITAL

Hand Symposium—On the Management of Acute Hand Diseases: South Baltimore General Hospital, 3001 Hanover St., Baltimore. Main speaker and moderator: Raymond C. Curtis, MD. Participants in the symposium and panel will be Drs. E. Berg, S. Wilgis, G. Clark, F. Hansen, M. A. Sarshar, G. Plaase, C. Tountas, A. Jasion, H. Wilhelmsen, M. Vahos, and L. Salazar. Contact: Neil Novin, MD, South Baltimore General Hospital.

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MARCH 14, 1970
HEART ASSOCIATION OF MARYLAND/MARYLAND ACADEMY OF GENERAL PRACTICE

Symposium—Myocardial Infarction, Before and During Hospitalization: 10 AM to 4 PM, South Baltimore General Hospital, Baltimore, Md. Contact: Mrs. Tyson (301) 685-7074, or Mrs. Holman (301) 661-1925.

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The Baltimore County Medical Association

The October meeting of the Baltimore County Medical Association at the Sparrows Point Country Club, on Saturday, October 25, 1969, was called to order by the President, Theodore Patterson, MD, who welcomed the wives and guests who were present. The minutes of the September meeting were approved as read. The Treasurer, John Krager, MD, reported a total of $21,208.24 in the treasury.

Barbara Solomon, MD, the association representative to the Council on Smoking, requested volunteers to set up a Smoking Withdrawal Clinic, starting early next year.

Four new members were admitted to active membership.

The speaker for the meeting was Mr. John Sargeant, Executive Secretary of the Medical and Chirurgical Faculty. He outlined several bills of interest to physicians which will probably be introduced in the state legislature.

After the business meeting was adjourned, a dinner-dance took place.

The November meeting of the Baltimore County Medical Association was held at St. Joseph Hospital on November 15, 1969, at the invitation of the Sisters of St. Francis and the hospital staff. The meeting started with a luncheon at 1:00 PM. The business meeting followed, under the direction of the Vice-President, Wilmer L. Gallager, MD. The minutes of the previous meeting were approved. The report of the Board of Governors was read by the Chairman, S. J. Venable, Jr., MD. The nominating committee announced the slate for the coming election; no further nominations were made from the floor. The Secretary, John Krager, MD, read the communications that were received. At the conclusion of the business meeting, Dr. Gallager turned the meeting over to Eugene Riley, MD, President of the Medical Staff of St. Joseph Hospital, who introduced the speakers for the Shock Seminar.

The first paper, "Management of Shock in Surgical Practice" was given by Robert B. Rutherford, MD, Associate Professor of Medicine at Johns Hopkins. Paul K. Hanashiro, MD, Assistant Professor of Medicine and Surgery at the University of Maryland School of Medicine, presented the second paper, entitled "Cardiogenic Shock." The final paper, "Coagulopathies in Shock," was given by Safum Attar, MD, Associate Professor of Thoracic and Cardiovascular Surgery at the University of Maryland School of Medicine. A question and answer period followed each presentation.

The meeting adjourned at 5:00 PM. Dr. Gallager thanked the Sisters of St. Francis and Dr. Riley and the Program Committee members for the excellent luncheon and scientific program. After the adjournment, the Woman's Auxiliary to the Baltimore County Medical Association hosted a cocktail party for the members of the Association and staff of St. Joseph Hospital and their wives.

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Ninth Semiannual Meeting of the Maryland Association of Medical Assistants

The Maryland Association of Medical Assistants held their ninth semiannual meeting in Ocean City, Maryland, on September 6, 1969. The business meeting was followed by a panel discussion narrated by Mrs. Dolly Stuck. Members of the panel included: Mrs. Dorothy Hartel, President, Baltimore Association of Medical Assistants; Mrs. Mabel Young, Allegany-Garrett Medical Assistants; Mrs. Frances Whittaker, President, Montgomery County Association of Medical Assistants; and Mrs. Doris Ward, President, Wicomico Association of Medical Assistants. The panel reviewed the problems and purposes of each local organization. A question and answer period followed the discussion and included opinions designed to better the state organization.



Dr. Todd

In the afternoon, Nevins Todd, MD, of Salisbury, Maryland, spoke on "Carcinoma of the Lung", giving many pertinent statistics relating cigarette smoking to lung cancer. Dr. Todd was born in Salisbury, and was graduated from Wicomico High School. He attended Syracuse University and received his MD degree from the University of Maryland School of Medicine in 1957. He completed his internship at the University of Maryland Hospital, and served with the U.S. Navy from 1958 to 1960. Upon completion of his general surgical residency at the University of Maryland Hospital, he served a two-year thoracic surgical residency at the same hospital. Dr. Todd was certified by the American Board of Surgery in February 1968, and he is presently in private practice as a thoracic surgeon in Salisbury, Maryland.



Mr. Whedbee

The events of the day were climaxed by a gala evening at the Ship's Cafe in Ocean City. Master of Ceremonies for the evening was Mr. Thomas G. Whedbee, Jr., Director of Church Home and Hospital in Baltimore. A native of North Carolina, Mr. Whedbee attended Wake Forest University, and, after serving with the U.S. Navy for four years, graduated from the Medical College of Virginia in 1960. That same year, he came to Church Home and Hospital as Assistant Director, and was appointed Director in 1965.

Following the dinner, members of the Baltimore Association of Medical Assistants presented "Laugh-Out, Smash-In". The medical assistants and guests thoroughly enjoyed the lighthearted entertainment presented by Mr. John Allen, Mrs. Dorothy Hartel, Mrs. Elva Edmonston, Mrs. Peggy Bury, Mrs. Mary Margaret Frederick, Mrs. Barbara Daniel, Mrs. William Leiby, and Miss Carmella Sartori.

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MEDIC
1970 SCHEDULE

JANUARY 30, 1970 — 12:30 PM

PORTAL CIRRHOSIS

George Zuidema, MD
Professor of Surgery
The Johns Hopkins University School of Medicine

The major life-threatening complication of hepatic cirrhosis is hemorrhage from gastroesophageal varices. Precise diagnosis and aggressive primary care are essential in successful patient management. Although many methods have been employed, emergency portacaval anastomosis remains the best method for control of variceal hemorrhage and definitive treatment of portal hypertension. Portal decompression also has a role in control of intractable cirrhotic ascites.

Sponsor: PROVIDENT HOSPITAL

Replays:	Monday, February 2, 1970	12:30 PM
	Wednesday, February 4, 1970	9:00 AM
		2:00 PM

FEBRUARY 6, 1970 — 12:30 PM

MENINGITIS

Fred McCrumb, MD
Professor of International Diseases
University of Maryland School of Medicine

Acute microbial disease of the central nervous system is manifested most frequently as the clinical syndrome of meningitis. A broad spectrum of bacterial and viral agents may be involved. Varied and specific identification, pathogenesis, and clinical management will be discussed.

Sponsor: SACRED HEART HOSPITAL

Replays:	Monday, February 9, 1970	12:30 PM
	Wednesday, February 11, 1970	9:00 AM
		2:00 PM

FEBRUARY 13, 1970 — 12:30 PM

MALABSORPTION

Thomas R. Hendrix, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

The differential problem represented by the presence of malabsorption in the adult will be reviewed, as well as material from the G.I. Clinic at The Johns Hopkins Hospital.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, February 16, 1970	12:30 PM
	Wednesday, February 18, 1970	9:00 AM
		2:00 PM

FEBRUARY 20, 1970 — 12:30 PM

SUBACUTE BACTERIAL ENDOCARDITIS

Patricia Charache, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Abou D. Pollack, MD
Chief of Pathology
Baltimore City Hospitals,
Associate Professor of Pathology
The Johns Hopkins University School of Medicine

The clinical and microbial diagnosis of subacute bacterial endocarditis, as well as the management of the patient with subacute endocarditis will be presented.

Sponsor: BALTIMORE CITY HOSPITALS

Replays: Monday, February 23, 1970 12:30 PM
Wednesday, February 25, 1970 9:00 AM
2:00 PM

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

January 27 February 24 March 24
April 28 May 26

POSTGRADUATE PROGRAMS
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(See page 108 for a list of participating hospitals and the standard weekly program schedule)

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THE MONTH IN WASHINGTON

A Senate subcommittee said that the number of medical malpractice suits probably will increase and "the situation threatens to become a national crisis."

Sen. Abraham Ribicoff (D., Conn.), chairman of the Subcommittee on Executive Reorganization which has been reviewing the federal role in the nation's health care problems for nearly two years, reported eight conclusions of an extensive staff study. They are:

"1. The number of malpractice suits and claims is rising sharply in certain regions of the country. The size of judgments and settlements is increasing rapidly.

"2. Most malpractice suits are the direct result of injuries suffered by patients during medical treatment or surgery. The majority have proved justifiable. These suits are the indirect result of a deterioration of the traditional physician-patient relationship.

"3. The publicity given to higher malpractice judgments and settlements, based frequently on new legal precedents, is likely to trigger increasing litigation in other states. The situation threatens to become a national crisis.

"4. Already, higher judgments and settlements are having the following direct results:

(a) Companies providing malpractice insurance are increasing the cost of coverage.

(b) These costs—in the form of higher charges—are being passed on to patients, their health care insurance companies, and federal health care programs.

"5. The rising number of malpractice suits is forcing physicians to practice what they call defensive medicine, viewing each patient as a potential malpractice claimant. Physicians often order excessive diagnostic procedures for patients, thereby increasing the cost of care. Moreover, they are declining to perform other procedures, which in themselves, may entail some risk of patient injury.

"6. At present, it appears that no one affected by the rise in malpractice suits and claims has been able to deal with this problem in a manner that promises to alleviate this situation.

"7. The lion's share of the total cost to the insurance companies of malpractice suits and claims goes to the legal community.

"8. There is a definite federal role in the malpractice problem."

Specialists listed as having "a greater potential exposure to malpractice suits" were orthopedic surgeons, general surgeons, neurosurgeons, anesthesiologists, obstetricians and gynecologists.

The 1150-page report included responses from staff inquiries to the American Medical Association, the American Hospital Association, lawyers and malpractice insurance companies.

If the situation continues to worsen, the report said, the federal government "may have to consider . . . a reinsurance pool to which it would contribute."

If the federal government moves into the malpractice area, the report said, it also should consider:

". . . whether medical or surgical injury to a patient is a community responsibility and therefore compensable by the community.

". . . whether it must provide legal aid to the poor to help them seek redress from personal medical or surgical injury.

". . . whether it will insist upon creation of more effective regulatory devices over health professionals and health facilities to assure that those who are providing care are competent to do so."

* * * *

A special task force recommended that the federal government experiment with different ways of paying physicians under medicare and medicaid.

In the first of a series of reports on medicaid, the task force —appointed by Health, Education and Welfare Secretary Robert H. Finch last July—said:

"HEW should actively program experiments for incentive reimbursement under medicare and medicaid, with new emphasis on experiments in payment methods for physicians as the key generators of health services. In addition to experiments in institutional reimbursement, other experiments could emphasize compensation to groups of practitioners using modified approaches to capitation with built-in controls on quality and costs."

The report said that states also should be made aware of options now available under present laws and regulations in addition to the individual fee-for-service basis for payments to physicians. The report listed "contract payments with quality controls, case average methods, and fee for time."

The task force recommended that medicaid funds be used to finance group practice, neighborhood health clinics and home health care programs, particularly in ghettos and other low-income areas.

The recommendation was the core of a goal "to effect changes and improvements in the health care delivery system" of the nation.

"Bringing about needed major changes in the organization and delivery of health services is a long-range objective, requiring national commitment and establishment of national policy and priorities," the task force said in the first of a series of reports.

"For the short range, we are recommending certain actions which could bring about some improvements and which are consistent with long-range objectives."

For the short range, it was recommended that 5% of federal medicaid funds be earmarked for state "development and improvement of health care services and resources." Consideration also should be given to such use of medicare funds, the report said.

The federal government was urged to take a more positive leadership role in the medicare program by first improving its own administrative machinery and then getting each state to make its management functions more efficient.

Other recommendations of the task force included:

• Deny federal medicaid funds to chiropractors and naturopaths; • Require uniform provisions and unified state standard setting, certification, and consultation functions with respect to providers of service under both medicaid and medicare; • Establish eligibility for medicaid benefits by permitting an applicant to fill out a simple declaration form; • Require "profiles at the state level of vendors and recipients of service, and criteria against which to screen claims to identify patterns which appear to deviate from desirable and/or usual behavior."

* * * *

The American Medical Association urged Congress to give top priority to appropriations that will help increase the number of physicians.

Testifying before a Senate appropriations subcommittee, **C. H. William Ruhe, MD,** director of the AMA's Division of Medical Education, said that "medical education should be supported financially as fully as possible to meet the pressing need which exists today for an increased number of physicians.

"We believe," he said, "that in any appropriation priorities established for all government programs, those which affect health care should be given primary consideration. Further, because of the special need . . . for more physicians, we urge that appropriations relevant to the production of physicians be given first priority."

Concerning decreases in the Administration budget in support of research and training grants, fellowships, library grants and research facility construction, the AMA spokesman said:

"It is difficult to estimate the effect these reductions will have upon efforts to increase physician production, but there is concern among many medical educators that the growth in medical school enrollments will be inhibited. We believe that this effect should be watched closely and corrective measures instituted promptly if physician production is impaired."

The AMA joined the Student American Medical Association and the Association of American Medical Colleges in a joint statement which said that "an increase in the appropriation for the Health Professions Student Loan Program is crucial."

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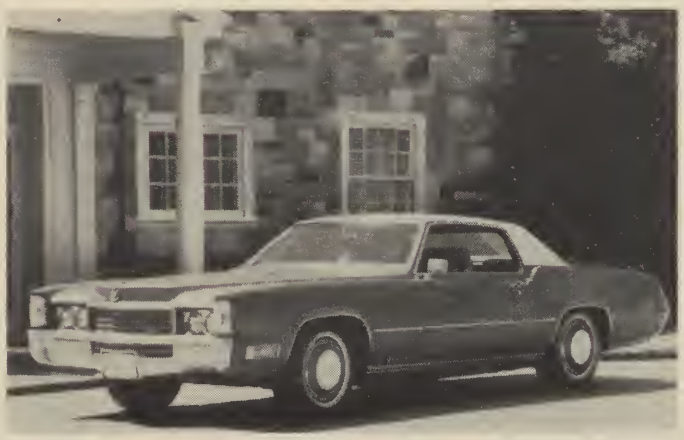
Physicians May be Bound to Disclose Credit Terms

Under the Federal Truth in Lending Act, which became effective July 1, 1969, a physician may be required to disclose, on statements sent to patients, the amount and terms of credit arrangements concerning his fees. Regulations issued under the Act apply not only to finance charges, but also to express agreements for payment of medical fees in more than four installments, either with or without finance charges. Detailed information on the regulations may be obtained from the nearest Federal Trade Commission office or by mail from the agency's headquarters, Washington, D.C. 20580. The information is contained in a booklet entitled "What You Ought To Know About Truth in Lending Consumer Credit Cost Disclosure," Federal Reserve Regulation Z.

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Professional Liability Insurance

A recent news story on medical liability rates in southern California received wide circulation nationally. The story stated that the average annual premium for 7,000 Los Angeles County physicians is $5,000.

Costs associated with malpractice are having an effect on medical costs, prompting some California physicians to increase fees for office calls by $1 per call. A place for arbitration of malpractice claims by a malpractice board is being considered by some physicians and hospital boards there. Legal issues are raised by such a plan, not to mention possible adverse effects on the physician-patient relationship.

Reportedly, malpractice insurance rates have gone up three times faster than the cost of living since World War II. Even so, annual losses on this type of business have been recorded by insurance carriers since 1959.

The following table lists current annual premiums for professional liability insurance available to ACOG Fellows for a representative coverage. The rates given are for solo practice; for a partnership add 20%* to the solo rate to determine each partner's premium.

Fellows seeking additional information or application forms may write the American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago, Illinois 60603.

* Except in California

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Arizona	1,580.00	Michigan	1,528.00	Pennsylvania	894.00
Arkansas	958.00	Minnesota	712.00	Puerto Rico	596.00
Calif. (Southern)	3,452.00	Mississippi	324.00	Rhode Island	479.00
(Northern) comparable to South.		Missouri	660.00	South Carolina	298.00
Colorado	1,088.00	Montana	1,049.00	South Dakota	458.00
Connecticut	622.00	Nebraska	376.00	Tennessee	738.00
Delaware	474.00	Nevada	1,580.00	Texas	518.00
Dist. of Columbia	945.00	New Hampshire	324.00	Utah	790.00
Florida (Dade County)	1,425.00	New Jersey	1,684.00	Vermont	492.00
Florida (remainder)	842.00	New Mexico	1,127.00	Virginia	660.00
Georgia	660.00	New York (N.Y.C. & Nassau County)	2,015.00	Washington	842.00
Hawaii	816.00	(Suffolk, Rockland, Sullivan & Ulster Counties)	1,854.00	West Virginia	492.00
Idaho	738.00	(Westchester & Orange Counties)	1,397.00	Wisconsin	699.00
Illinois	609.00	N.Y. (remainder)	1,088.00	Wyoming	453.00
Indiana	673.00	North Carolina	268.00	Active Military Service (except Dela. & New York)	194.00
Iowa	803.00	North Dakota	466.00	Active Military Service (Delaware & New York)	155.00
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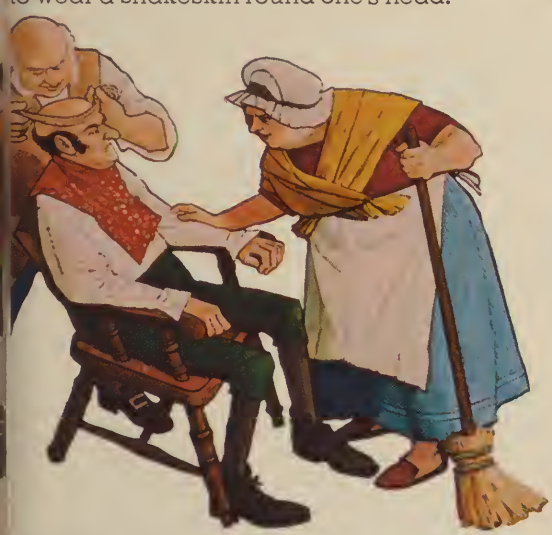
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Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma

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Stevens-Johnson syndrome, 's syndrome (toxic necrotizing ermolysis), or a generalized gic reaction similar to serum ness may occur and require anent withdrawal of medica- Agranulocytosis can occur enly in spite of regular, repeated nal white counts. Stomatitis rarely, salivary gland enlarge- may require cessation of treat- t. Such patients should not ve subsequent courses of the . Vomiting, vertigo and languor occur. Leukemia and leukemoid ions have been reported. While definitely attributable to the , a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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INFORMED CONSENT

Cases brought against physicians based upon failure to obtain "informed" consent are on the increase.

One court has held that physicians must inform their patients, in plain language, about:

1. The nature of the ailment;
2. The nature of the proposed treatment;
3. The probability of success of alternatives;
4. The risks of unfortunate results and unforeseen conditions within the body, in some cases.

Other courts have referred to the obligation to make "reasonable" disclosure, and have stated that physicians are not required to set forth overly broad explanations of risks where they might make patients unduly apprehensive. They have further stated that physicians could withhold information where it would jeopardize the patient's recovery.

Obviously, the law is not entirely clear on the subject of informed consent. But one thing **is** clear.

Nothing is more important than good doctor-patient relationships, based upon mutual respect and confidence.

Enlist your patient's intelligent cooperation by explaining **what** you intend to do, and **why.** Inform the patient or, where indicated, a responsible member of his family of the potential dangers that are involved.

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ILLUSTRATED DICTIONARY OF EPONYMIC SYNDROMES AND DISEASES AND THEIR SYNONYMS, Stanley Jablonski; The W. B. Saunders Company, Philadelphia, Pa. 1969.

This book attempts to unravel difficulties in communication by presenting the vast profusion of eponyms and descriptive synonyms that are used to designate syndromes and diseases. It succeeds admirably. The American form of alphabetizing and spelling are used throughout. In addition, the eponymic names of pathological conditions, named after discoverers, literary and mythological characters, as well as patients, are all cross-referenced. Only terms used at least twice in the literature were included in the dictionary, which is an excellent volume to add to a reference library.

FUNDAMENTALS OF INHALATION THERAPY, Donald F. Egan, MD; The C. V. Mosby Company, St. Louis, Mo. 1969.

This book provides what is accepted as minimum knowledge for safe and effective administration of inhalation therapy. It is intended primarily for the student inhalation therapist and for the working therapist who requires a reference for review, but is also recommended for the practicing physician. The book furthers the physician's understanding of the fundamentals of the therapy he prescribes in an attempt to increase his knowledge of its use and expectations.

Dr. Egan's book is being added to the Faculty library, and will increase the scope of works in this field and make available, to those interested, additional such material.

ATLAS OF OBSTETRIC TECHNIC, J. Robert Willson, MD; The C. V. Mosby Company, St. Louis, Mo. 1969.

Although the illustrations have not been changed, the text of the second edition of this publication has been completely revised to include newer methods, techniques, tests, and procedures in obstetrics. Primarily a reference text for residents and physicians, this book is also helpful to medical students.

ACUTE RENAL FAILURE, Robert C. Muehrcke, MD; The C. V. Mosby Company, St. Louis, Mo. 1969.

This book illustrates the diagnosis and management of patients with acute renal failure, and is intended for use by physicians in all fields of medicine, as well as by medical students. It outlines the vast spectrum of acute oliguric renal failure: the complex etiology, the numerous pathogenic conditions, the tedious management, and varied prognoses of the disease. Not intended as an encyclopedia on renal failure, this book merely describes the broad variations in the clinical course of patients with this condition.

STUDIES IN CLINICAL ENZYMOLOGY, D. P. Mullan, MD; The C. V. Mosby Company, St. Louis, Mo. 1969.

Dr. Mullan has taken several topics within the field of clinical enzymology and has described the enzyme changes that occur. This book is well documented: It includes a lengthy list of credits to the consultants who worked with Dr. Mullan in preparing this book. Of particular interest are the sections on Nairobi patients, and enzyme changes in African heart disease patients in Nigeria.

The monograph covers a wide field of interest. It has special interest for the obstetrician, pediatrician, neurologist, and those interested in tropical medicine, and is well worth reading.

SCHIZOPHRENIA AND THE NEED-FEAR DILEMMA, Donald L. Burnham, MD, Arthur I. Gladstone, PhD, and Robert W. Gibson, MD; International Universities Press, Inc., New York, New York 1969.

This book presents clinical histories in an attempt to explain the nature of the human experience of the schizophrenic individual. The authors offer a structural psychological theory to account for the observed behavior and reported feelings of the patient, relating these to the changes in the course of personality development. The schizophrenic person is not regarded as a deteriorated individual, cut off from others by an autistic barrier, and out of touch with reality; the authors see the symptoms of the patient as an adaptive effort in an attempt to organize his world. In the acknowledgements section of the book, credit is given to the clinical facilities of the Chestnut Lodge Research Institute, of Rockville, Maryland, which were used in this study, under the direction of Dexter M. Bullard, MD, for its "excellent clinical program." This, then, is truly a Maryland project. It is a book well worth reading and keeping for reference purposes.

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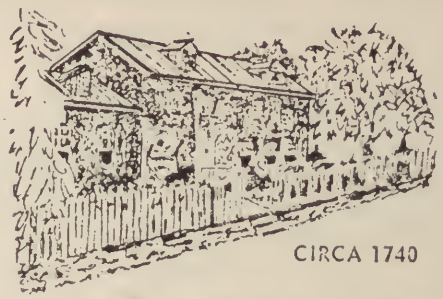
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MEDICAL NEWS

Russell S. Fisher, MD, Chief Medical Examiner for Maryland, along with representatives from the American Medical Association and the American Association of Medical Assistants, are consultants to a new film entitled "Case in Point", which outlines the precautions the medical assistant and her physician-employer can take to protect themselves from lawsuits. A documentary film, it depicts professional activities of the medical assistant, and shows the importance of observing certain safeguards in such areas as office medical procedures, record keeping, dangerous conditions in the doctor's office, relations with patients, and handling of information about patients.

"Case in Point" is jointly produced by the American Association of Medical Assistants and Wyeth Laboratories.



Dr. Fisher

* * *

The following Maryland physicians were recently elected to Fellowship in the American College of Physicians: **Robert O. Biern, MD; Torrey C. Brown, MD; Arthur E. Cocco, MD; Richard J. Johns, MD; Patricia A. McIntyre, MD; Joseph S. Redding, MD; Alexander S. Townes, MD; William V. Zussman, MD; Emidio A. Bianco, MD;** and **A. Austin Pearre, Jr., MD.**

* * *

Jonas Rappeport, MD, of Baltimore, has been elected president of the newly formed American Academy of Psychiatry and Law, which held its first meeting at the Friendship International Hotel on November 16, 1969. Dr. Rappeport has also been named to serve a one-year term on the AMA Committee on Medicolegal Problems, starting January 1, 1970.

* * *

St. Agnes Hospital's blood bank has been accredited by the American Association of Blood Banks, with headquarters in Chicago, Illinois. The announcement was made by the Association's president, Frank C. Coleman, MD.

* * *

Gerard F. Devlin, Maryland's Federal Relations Officer, was asked by President Nixon to participate in the **White House Conference on Food, Nutrition and Health,** held in Washington, DC, December 1 through December 4. A member of Governor Mandel's Commission on Childhood Nutrition, Mr. Devlin has been assigned by the President to work with the Conference's State and Local Government Panel.

* * *

The development of a new orthopedic cast material, **Lightcast,** a lightweight, strong, moisture-resistant, resin-impregnated fiberglass tape, has been announced by **Solar Laboratories, Inc.,** of Gardena, California. The new material, designed to replace the plaster cast, was introduced in conjunction with medical meetings of the Americal Academy of General Practice and the Western Orthopedic Association.

The cast allows for air circulation, and is soft and flexible. The tape is wrapped around the fracture and then cured by exposure to a specific wave-length light to form a hard, lightweight cast. It is only about one third the weight, and allows for more comfort and mobility than the old version, and permits the wearing of normal clothing over the cast.

* * *

The Commonwealth Fund, the American philanthropic foundation, has made a grant to **The Johns Hopkins University School of Medicine,** which will enable the school to expand and continue its faculty and post-doctoral program with the medical schools of the American University of Beirut, Lebanon, and the Peruvian University Cayetano Heredia, in Lima.

* * *

Hugh M. Hill, MD, FACOG, professor of obstetrics and gynecology at the University of Florida College of Medicine in Gainesville, received the school's first Hippocratic Award for Teaching Excellence. Originated by the class of 1969, the award will be presented annually to the teacher who, in the opinion of the students, most enriched their minds during their four years in medical school. Dr. Hill, who joined the faculty in 1957, is a graduate of Davidson College, Davidson, N.C. He received his MD degree from The Johns Hopkins University School of Medicine.

The presentation was made in conjunction with the planting of a cutting from the ancient

sycamore tree under which the father of medicine, Hippocrates, reputedly taught in the fifth century B. C. Dr. Hill's name was inscribed on a plaque mounted on a large stone at the base of the tree.

* * *

The American Board of Obstetrics and Gynecology has announced its schedule of examinations for the coming two years.

Applications for the written exams must be postmarked on or before November 30, 1970 or November 30, 1971 in order for the applicant to be considered for the written examination on June 21, 1971 or June 19, 1972, respectively.

For the orals, applications must be postmarked *between* January 1 and February 28, 1970, January 1 and February 28, 1971, and January 1 and February 28, 1972 in order to be considered for examinations on November 2-6, 1970, November 1-5, 1971, and October 30-November 3, 1972, respectively.

For additional information write: Clyde L. Randall, MD, Secretary-Treasurer, American Board of Obstetrics and Gynecology, 100 Meadow Rd., Buffalo, N. Y. 14216. Phone: (716) 875-1573.

* * *

In a statement appearing in the November 1969 issue of the American Academy of Pediatrics Journal, *Pediatrics,* the Academy's **Committee on International Child Health** called for the establishment of community health centers throughout North, Middle, and South America to study and develop methods which will identify, reduce, and eventually help prevent the avoidable illnesses and nutritional deficiencies which lead to infant mortality. Such methods would include family planning.

* * *

Early in December, **Dana L. Farnsworth, MD,** Chairman of the AMA Council on Mental Health, appeared before the Senate Committee on the District of Columbia to present the Association's support of the District of Columbia Comprehensive Drug Abuse and Narcotic Crime Control Act of 1969. The Act calls for a comprehensive program for the control of drug abuse and drug related crime through improved law inforcement, the strict regulation of the distribution of controlled drugs, and the prevention, treatment, and study of drug abuse and drug dependence.

* * *

Senator Proxmire (D., Wisc.) introduced the **Regional Water Quality Bill** early in December, which is aimed at penalizing industries which pollute rivers and streams. Under the proposal, a schedule of substantial fees would be charged an industry for polluting rivers and streams, depending upon the quantity and toxicity of the pollution. Half of the money received would help finance local waste treatment projects; the remainder would be used for regional pollution planning projects. The bill was referred to the Senate Committee on Public Works.

* * *

Episodic Behavioral Disorders, by **Russell R. Monroe, MD,** of the University of Maryland School of Medicine, is one of the six manuscripts completed and accepted by the Harvard University Press, the Commonwealth Fund's cooperating publisher. Dr. Monroe's manuscript deals with the "classification and analysis of recurrent behavioral abnormalities stemming from episodic mental illness and neurophysiologic disorders, including epilepsy."

* * *

Applications are now being accepted for the **E. V. Allen Memorial Scholarships,** open to junior and senior medical students attending medical schools in the United States or Canada. The scholarship provides three months of cardiovascular study at the Mayo Clinic in Rochester, Minnesota, as well as a $1,000 award. Deadline for applications is April 1, 1970; applicants will be notified by May 1, 1970.

Brochures may be obtained by writing to the Minnesota Heart Association, 4701 West 77th Street, Edina, Minnesota 55435.

* * *

On November 20, 1969, HEW Secretary Robert H. Finch accepted recommendations of a **Medical Advisory Group on Cyclamates,** which previously had weighed the potential benefits of non-nutritive sweeteners such as cyclamate against any possible harmful effects. The scientific group stated that the medical benefits outweighed the possibility of harm in weight control programs, and for use by diabetics. The physicians also recommended that foods containing cyclamates continue to be available, but would include a warning and a statement of the cyclamate content of an average serving on the label.

* * *

Curt P. Richter, PhD, Professor Emeritus of Psychobiology at The Johns Hopkins University School of Medicine, and an honorary member of the Baltimore City Medical Society, has received support from the Commonwealth Fund Book program for his project on the 24-hour time cycle in the regulation of behavorial and metabolic functions in animals and man.

* * *

Julius R. Krevans, MD, Professor of Medicine and Dean of Academic Affairs at Johns Hopkins, along with other distinguished medical educators, recently participated in a series of

informal meetings, also attended by staff members of the Carnegie Corporation and the Commonwealth Fund, which provided start-up grants for this collaborative program to underwrite the employment of a full-time faculty program director at each represented school for a two-year period. Each of the Departments of Medicine will encourage faculty from throughout the university to participate in the activities of the Department, permitting them to advance their plans to extend graduate specialty education for interns and residents and produce a significant number of clinical scholars.

* * *

The 1969 Griffin Award was presented to **Melvin M. Rabstein, DVM,** Chief of the Animal Farm Division at Fort Detrick, in Frederick, at the 20th Annual Session of the American Association for Laboratory Animal Science, held in Dallas, Texas, in October 1969, for his outstanding accomplishments in the improvement of the care and quality of animals used in biological and medical research. **Edward C. Melby, Jr., DVM,** of The Johns Hopkins University in Baltimore, was installed as AALAS president for the coming year.

* * *

In December 1969, members of the **American Medical Association,** the **Student American Medical Association,** and the **Association of American Medical Colleges** presented a joint statement before the Subcommittee on Labor and HEW of the Senate Appropriations Committee, in support of full funding of the Health Professions Student Loan Program. They stressed continued support of the program that would further the recruitment of medical students from financially disadvantaged backgrounds and provide them with substantial financial support to complete their medical education. The AMA representatives also asked for aid in improving the medical library and educational facilities.

* * *

The Maryland Association For Mental Health and its president, **Reuben Shiling,** have expressed approval of the decision made by the Secretary of Health and Mental Hygiene, **Neil Solomon, MD, PhD,** to resume planning and construction work for Baltimore's **Inner City Community Mental Health Center.** According to Mr. Shiling, "We hope this means that the plans of the Department of Mental Hygiene, as presently conceived under Commissioner Dr. James Carson, will be given high priority."

* * *

Recipients of the **27th Gorgas Medal** for 1969 are **Karl M. Johnson, MD,** and his wife **Patricia A. Webb, MD,** both members of the U. S. Public Health Service working in the Panama Canal Zone. The medal, with a citation and an honorarium, was recently presented to the husband-wife team at the annual meeting of the Association of Military Surgeons of the United States, for their "research efforts to prevent and eradicate Bolivian Hemorrhagic Fever, and for their dedication to the improved health of the peoples of Central and South America."

The award was established in 1942 by Wyeth Laboratories to honor Major General William C. Gorgas, whose public health programs in the Panama Canal Zone over 60 years ago helped to control yellow fever and malaria in Panama, and thus made possible the building of the Panama Canal. Each year, the Association of Military Surgeons selects the individual to be honored for contributions in the field of preventive medicine.

* * *

(Continued next page)



Gorgas Medal winners for outstanding accomplishments in preventive medicine are (from right) Karl M. Johnson, MD, and his wife, Patricia A. Webb, MD, both of the U.S. Public Health Service working in the Panama Canal Zone. Presenting the award is George E. Farrar, Jr., Director of Medical Services for Wyeth Laboratories, sponsors of the Medal.

Sheppard Kaplow, MD, of Baltimore; **Shakuntla Devi Mahajan,** MB, of Hyattsville; and **John P. Swope, MD,** of Bethesda, members of the American Society of Anesthesiologists, have recently been named Fellows of the Society.

* * *

The following physicians have each served a two-month tour in the **Volunteer Physicians for Viet Nam** program: **Robert E. Eby, MD,** of College Park; **Andre V. Fesus, MD,** of Baltimore; **Michael B. Flynn, MD,** of Baltimore. **Wayne K. Foster, MD,** of Cecilton, served four two-month tours. **Stephen M. Nagy, Jr., MD,** of Baltimore. **Louis Padovano, MD,** of Woodstock, and **Thomas H. Powell, MD,** of Baltimore, served two two-month tours. **Glendon E. Rayson, MD,** of Baltimore; **Patrick A. Reardon, MD,** of Seabrook; **Donald K. Wallace, MD,** of Baltimore; and **Celeste L. Woodward, MD,** of Baltimore, served one tour.

* * *

On December 3, 1969, former U. S. Attorney General **Nicholas deB. Katzenbach** spoke on drug addiction and rehabilitation at the eighth annual meeting of the **Anne Arundel County Mental Health Association** in Annapolis, a meeting co-sponsored by the Mental Health Association and the Anne Arundel County Jaycees.

Mr. Katzenbach is presently Chairman of the Board of the Narcotics Addiction Research and Treatment Corporation of New York City.

* * *

The Columbia Hospital and Clinics Foundation, of Columbia, Maryland, an affiliate of The Johns Hopkins Medical Institutions, officially opened October 1, 1969. The Columbia Clinic, an experiment in health care delivery, is complete with a laboratory and X-ray rooms. Until the permanent hospital is built in Columbia, hospital services to members of the Columbia Medical Plan will be provided at the Clinic.

* * *

Carolyn S. Pincock, MD, a pediatrician from Silver Spring, has been elected 66th president of the Montgomery County Medical Society. She succeeds **Merton L. White, MD,** who recently retired. At the Society's annual dinner dance, Dr. Pincock was given the "Henry P. Laughlin" award for outstanding service in the field of adolescent medicine.

Dr. Pincock is active in the Maryland Chapter of the American Academy of Pediatrics and is a past president of the American Medical Woman's Association.



Dr. Pincock

* * *

A project supported by a $300,000 grant from the National Institute of Mental Health is underway at **The Johns Hopkins Medical Institutions** to study women suffering from depression. Hopefully, knowledge gained from this study will further effective treatment methods for outpatients in private offices and clinics. The project, headed by study director **Lino Covi, MD,** will evaluate the effects of certain anti-depressant drugs upon depressed women being treated as outpatients, and also examine the influence of group psychotherapy when used in conjunction with the drugs.

Volunteers are still needed for the study. Applicants must be depressed women between 20 and 60 years of age, but not psychotic or in need of hospitalization. They cannot be alcoholics or addicts, and must be free of liver and cardiovascular diseases. Patients may be referred by physicians, or may contact Dr. Covi at The Johns Hopkins Hospital.

* * *

Among the newly elected members to the board of directors of the National Society for the Prevention of Blindness is **Richard E. Hoover, MD,** an ophthalmologist from Baltimore, and a member of the NSPB Committee on Low Vision Aids. Dr. Hoover will serve a three-year term.

* * *

Robert W. Berliner, MD, Deputy Director for Science at the National Institutes of Health, in his presidential address before the American Society of Nephrology on December 1, 1969, suggested using "the equivalent of a brief commercial before each therapeutic measure, of each dose of vaccine, each effective drug," to stress the critical link between medical research and adequate medical care. Dr. Berliner underlined the important role of research in developing an ability to distinguish hasty assertion from documented fact. He warned against "the tendency in medical education to abandon rigor and firm basic physiologic understanding in favor of the once-over-lightly in science and a heavy layer of community dynamics."

Dr. Berliner, one of the world's foremost renal physiolo-

gists, is credited with leading the way to understanding the balance of sodium and potassium salts in the blood, the mode of transfer of electrolytes across the kidney tubules, and the development of theories on the mechanism of urinary dilution and concentration.

* * *

George N. Webb, MS, of The Johns Hopkins University Medical School, will be among the speakers at the Second National Conference and Exposition on Electronics in Medicine, to be held at the Fairmont Hotel in San Francisco on February 12-14, 1970. The meeting is sponsored by the Electronics Management Center of McGraw-Hill Publications Company.

The Conference will present specific seminar-style discussions of problems and developments in medical engineering, instrumentation, and data handling, as well as two afternoons of concurrent workshops and an expanded display of electronics equipment used in the medical field.

Roger O. Egeberg, MD, Assistant Secretary of the Department of Health, Education and Welfare will also address the many medical and engineering specialists from around the world.

* * *

Solomon H. Snyder, MD, of Baltimore, has been awarded the Maryland Academy of Sciences' 1969 "Outstanding Young Scientist Award" for his significant contributions that will lead to more certain recognition and predictability of the action of hallucinogenic drugs, and more efficacious management of Parkinsonism and mental illness. The associate professor of pharmacology and psychiatry at The Johns Hopkins University School of Medicine received the Allan C. Davis Medal and a $500 check at a banquet held at the Belvedere Hotel in Baltimore on December 8, 1969.

A 1962 graduate of Georgetown Medical School, Dr. Snyder is making significant contributions in research on the amines in nervous tissue, on the pineal gland, and on histamine and histidine metabolism. Judges for this year's award included **Herman Z. Cummins, MD,** professor of physics, The Johns Hopkins University School of Medicine, and **Leon Weiss, MD,** professor of anatomy, The Johns Hopkins University School of Medicine.

* * *

In a recent *Bulletin* of the American Academy of Orthopaedic Surgeons, **Allen Fiske Voshell, MD,** was featured as the "orthopaedic personality" of the month. Dr. Voshell has been one of Baltimore's outstanding leaders in the field of orthopaedic surgery for many years. He graduated from The Johns Hopkins University in 1915, and from the medical school of that university in 1919. Following graduation, he served a one-year internship in orthopaedic surgery at The Johns Hopkins Hospital, and a one-year residency in the same field. In 1921, he organized the Department of Orthopaedic Surgery at the University of Virginia, and an effective program of rural clinics. Ten years later, he returned to Baltimore to accept two positions: Professor of Orthopaedic Surgery at the University of Maryland School of Medicine, and Surgeon-in-Chief of the James Lawrence Kernan Hospital for Crippled Children. He was responsible for developing Departments of Physical and Occupational Therapy, organizing rural clinics for the State Health Department, and setting up coordinated residency training programs in several affiliated hospitals.

Although now retired, Dr. Voshell still maintains a private practice and indulges in research. His major interest is the anatomy and mechanics of the knee joint, which led to his receiving the Gold Medal of the American Academy of Orthopaedic Surgeons in January 1941 for his exhibit on "The Mechanics and the Ligaments and Menisci of the Knee Joint." He was on the American Board of Orthopaedic Surgery from 1942 to 1951, and served as its president from 1949 to 1951.

* * *



Governor Mandel

Governor Marvin Mandel is considering legislation that would allow parents to report children suspected of using drugs to law enforcement authorities without fear of prosecution or criminal record. He also supports legislation introduced in the U. S. Senate by Senator Joseph D. Tydings that would strengthen the penalties for narcotics wholesalers and the position of law enforcement officials in apprehending sellers of drugs. Governor Mandel has asked the newly-created Maryland Drug Abuse Authority to review both recommendations which are directly aimed at suppliers of drugs and the rehabilitation of users. A special brochure is also being prepared that will help parents detect drug use by their children, and will also provide information on securing help for such youngsters.

* * *

Medical and Chirurgical Faculty

The scientific sessions of the 1970 Annual Meeting will be held at the Alcazar in Baltimore. Scheduled to present papers are

William P. Beetham, Jr., MD
Lahey Clinic Foundation
Boston

Daniel M. Gordon, MD
Associate Professor of Ophthalmology
Cornell University Medical College
New York

George James, MD, Dean
Mount Sinai School of Medicine
New York

Roy W. Menninger, MD, President
The Menninger Foundation
Topeka, Kansas

William H. Moretz, MD, Chairman
Department of Surgery
Medical College of Georgia

Hu C. Myers, MD
The Myers Clinic
Philippi, West Virginia

John Rock, MD
Clinical Professor Emeritus of Gynecology
Harvard Medical School
Director, Rock Reproductive Clinic, Inc.
Cambridge, Massachusetts

Frank C. Spencer, MD
Department of Surgery
New York University
New York

Felix Wroblewski, MD
Associate Professor of Clinical Medicine
Cornell University Medical College
New York

Medical Grand Rounds will be presented by A. McGehee Harvey, MD, and staff members of the Department of Medicine of The Johns Hopkins University. Surgical Grand Rounds will be presented by Robert W. Buxton, MD, and staff members of the Department of Surgery of the University of Maryland.

Other activities scheduled are

Annual Round-Table Luncheon, at the Belvedere Hotel, will include luncheon meetings of the alumni associations of several medical schools, and informal scientific discussions

Hospitality Night—this proved so very popular at the 1969 Meeting, that it will be repeated in 1970 at the Belvedere Hotel—vocal and instrumental entertainment will be provided

Annual Presidential Reception and Banquet—at the Blue Crest North, well known for its delectable cuisine, hors d'oeuvres, and cocktails—in a delightful atmosphere with professional entertainment, and dancing for everyone to the music of Rivers Chambers' Orchestra

Arts and Hobby Exhibit—at the Alcazar—a chance for you to put your unusual talents on display (see page 59 for the application form)

Health Evaluation Tests—at the Alcazar—an easy way to augment your annual checkup

Scientific and technical exhibits will be on display each day of Annual Meeting at the Alcazar—the exhibits constitute a symposium on therapeutic progress

Committee on Program and Arrangements
DeWitt E. DeLawter, MD, *Chairman*

172nd ANNUAL MEETING

of the State of Maryland

APRIL 1, 2, 3

Among the many prominent physicians who will speak at the Annual Meeting are Doctors **Dan Gordon, George James, Roy Menninger, and William Moretz.**

Roy W. Menninger, MD, will open the scientific program on Wednesday, April 1 with a discussion of the physician-patient relationship, and the problems of managing a neurotic patient. Dr. Menninger is the fourth president of the world famous Menninger Foundation of Topeka, Kansas, a nonprofit organization devoted to psychiatric treatment and research, preventive psychiatry, and professional education in psychiatry and the allied mental health fields. The eldest son of the late William C. Menninger, MD, Dr. Menninger joined the staff of the Foundation in 1961. Prior to his election as President, he was Director of the Department of Preventive Psychiatry.



Dr. Menninger

A Fellow of the American Psychiatric Association and the American College of Physicians, Dr. Menninger is also an active member of the Group for the Advancement of Psychiatry, the American Association for the Advancement of Science, the American Orthopsychiatric Association, and many other organizations.

Dr. Menninger graduated from Swarthmore College and received his medical doctorate from the Cornell University Medical College. His psychiatric residency was taken at three Boston Hospitals: Boston State, Boston Psychopathic, and Peter Bent Brigham. He served as Chief of Neuropsychiatry at an Army Hospital in Salzburg, Austria.

Special interests of Dr. Menninger are social and community psychiatry, school mental health, group therapy, and psychiatric education for general practitioners and internists. His personal hobbies and sports include collecting stamps and minerals, model railroading, camping, cello, civic symphony, and bicycling.

On Friday morning, April 3, **William H. Moretz, MD,** Chairman of the Department of Surgery at the Eugene Talmadge Memorial Hospital, Medical College of Georgia, will speak on "Pulmonary Embolism: Its Causes and Prevention." Dr. Moretz received his BS degree from Lenoir Rhyne College, attended the University of North Carolina School of Medicine, and received his MD degree from Harvard Medical School. Surgical training at the Strong Memorial Hospital in Rochester, New York, was followed by an instructorship in surgery at the University of Rochester School of Medicine. From 1947 to 1955, Dr. Moretz was Assistant Professor of Surgery and Associate Professor of Surgery at the University of Utah School of Medicine. In 1955 he was appointed professor of surgery and chairman of the Department of Surgery at the Medical College of Georgia, positions that he still holds.



Dr. Moretz

Dr. Moretz is a member and fellow of numerous surgical associations including the Society of University Surgeons, Southern Surgical Association, American Surgical Association, International Surgical Society, and the American College of Surgeons. He is a diplomate and a member of the American Board of Surgery. Vascular diseases and acute surgical diseases of the abdomen are among his research interests.

"The Future of Medical Education: Undergraduate and Postgraduate" will be the title of the paper presented by **George James, MD,** on Wednesday afternoon, April 1.

As a BA graduate of Columbia University, Dr. James received his medical degree at Yale University. He also holds a Master of Public Health degree from The Johns Hopkins University. He began his professional career in public health in 1942 in Tennessee, where he became health officer for Obion and Lake Counties, serving in that capacity for two years. Since then, he has been Commissioner of Health in Ulster County, New York; Assistant Commissioner in the New York State Department of Health; and Director of Health for the City of Akron, Ohio. He worked with the New York City Department of Health from 1956 to 1965, the last three years as Commissioner of Health, and Chairman of the Board of Health.



Dr. James

Dr. James left his position as Commissioner of Health of New York City to join Mount Sinai in 1965 as Dean of the School of Medicine, and in 1968 became President of the Medical Center.

Some of the offices he has held in professional organizations and government agencies include: vice president for Public Health, American College of Preventive Medicine; chairman of the committees of the American Public Health Association in such areas as health manpower, primary prevention, and professional examination service; president, Conference of County, City, and District Health Officers of New York State; vice chairman, Interdepartmental Health Council; and president of the Medical and Health Research Association of New York, Medical Library Center of New York, National Health Council, New York City Public Health Association, and New York State Academy of Preventive Medicine.

Dr. James has been active as a medical educator for many years, with service on the faculties of Yale University, The Johns Hopkins University, Albany Medical College, Columbia University, Harvard University, and the St. John's University School of Education.

Dan M. Gordon, MD, of New York, will speak on a subject of wide interest to general practitioners and internists, as well as to ophthalmologists: "The Eye in Systemic Disease". Dr. Gordon received both his BS and MD degrees at the University of Michigan.

Since 1963, Dr. Gordon has been Associate Professor (surgery) of Ophthalmology at Cornell University Medical College. Prior to this appointment, his training included positions as resident at the Illinois Eye and Ear Infirmary, surgeon at the New York Hospital, associate attending surgeon at the New York Hospital, and consultant assistant in Ophthalmology at the Memorial Hospital in New York City.



Dr. Gordon

Dr. Gordon is a fellow of the American College of Surgeons, the New York Academy of Medicine, and American Academy of Ophthalmology and Otolaryngology, in addition to holding memberships in many other medical and scientific societies. Among the books he has had published are "Medical Management of Ocular Disease", and "Uveitis, International Ophthalmology Clinic". He is Editor of "International Ophthalmology Clinics—Volumes 7 and 8, 1967-69". He has also had published approximately 160 articles in various medical journals.

Dr. Gordon is a breeder and judge of boxer dogs, and is the author of six books on these dogs.

THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM

of the

MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING

at the Alcazar

APRIL 1, 2, 3, 1970

TECHNICAL EXHIBITORS

(as of December 15, 1969)

Abbott Laboratories
Apache Oil Programs, Inc.
Ayerst Laboratories
Baltimore Dictating Machine Company
Bristol Laboratories
Ciba Pharmaceutical Company
Herbert Cox, Correct Shoes
Doctors Supply Company
Eaton Laboratories
The Emko Company
Encyclopaedia Britannica, Inc.
Flint Laboratories
Graymar Company
Hoechst Pharmaceutical Company
Knoll Pharmaceutical Company
Lakeside Laboratories, Inc.
Lederle Laboratories
Eli Lilly and Company
Marion Laboratories, Inc.
Maryland Blue Cross and Blue Shield Plans
Mead Johnson Laboratories
Medco Products Company, Inc.
Merck Sharp & Dohme
Merrill Lynch, Pierce, Fenner & Smith, Inc.
Murray Baumgartner Surgical Instrument Co.
Wm. P. Poythress & Company, Inc.
William H. Rorer, Inc.
Sandoz Pharmaceuticals
W. B. Saunders Company
G. D. Searle & Company
Security House, Inc.-The Denver Corp.
Skill Surgical, Inc.
Smith, Miller & Patch, Inc.
E. R. Squibb & Sons, Inc.
Sun Life Assurance Company of Canada
Warner-Chilcott Laboratories, Inc.

Smith Kline & French Laboratories, Geigy Pharmaceuticals and Hynson, Westcott & Dunning, Inc., are making a contribution, although they are unable to have exhibits this year.

ARTS AND HOBBY EXHIBIT

Annual Meeting of the Medical and Chirurgical Faculty

APRIL 1, 2, 3, 1970 The Alcazar, Baltimore

APPLICATION FOR ARTS AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Arts and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height: .....

3. Electrical or other requirements: .....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

An Arts and Hobby Exhibit will be held during the 172nd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible. Entries will be accepted until all exhibit space is allotted. Please have exhibits framed or mounted.

Entries should be delivered to The Alcazar, Cathedral and Madison Streets, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, March 31. They must be removed on Friday, April 3, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit.

Certificates will be awarded to the prize-winning exhibits. The names of exhibitors received by February 1, 1970, will be listed in the printed Annual Meeting program. However, all entries should be submitted as early as possible.

Committee for Arts and Hobby Exhibits:

Mrs. Charles H. Williams, *Chairman*
Mrs. George H. Yeager, *Chairman, Judging*
Mrs. Kurt Lederer
Mrs. Marvin I. Mones

MAKE YOUR HOTEL ROOM RESERVATIONS NOW

for the

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

APRIL 1, 2, 3, 1970

A block of rooms has been set aside at the BELVEDERE HOTEL, Baltimore, for those attending this meeting. Because of many activities in the city, rooms will be at a premium.

The rates are $19.00 for a double or twin bedded room for two persons; single occupancy rate is $15.00; and suites are $25, $30, and $40.00.

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Address ..... City ..... State .....

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She needs time for her husband . . .
and for herself as well . . . .
so that she can come to terms
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and responsibilities now facing her.
She needs time to decide
when she will have additional children
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Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

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Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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The Commission on Medical Discipline

Adopted by the 1968 State Legislature, and effective July 1, 1969, the Commission on Medical Discipline provides a clear mandate to the profession for self-policing. The nine men who comprise this group are charged with making a judicial determination on evidence referred to the Commission by the Medical and Chirurgical Faculty. Individual component societies are also involved, for complaints originating from any source are referred to the local level for interpretation and possible recommendations for disciplinary action. The local society may refer the matter for judgment on a state level. Such complaints must be followed by a report to the Commission within 90 days.

In its initial stages, the Commission has already received three cases pending within the Board of Medical Examiners. Several other cases have been submitted to the Faculty for investigation and a report to the Commission. In addition, a Commission on Optometry Discipline has been established, and a proposal for a Commission on Dental Discipline is under consideration.

The law establishing the Commission on Medical Discipline clearly outlines the grounds for taking appropriate action. The clarity of this law is a great improvement over the previous statute, which was somewhat vague and often ambiguous. Under the old law, a physician against whom a complaint was filed could easily avoid punishment because of legal technicalities. With increasing attacks on the medical profession and its alleged shortcomings, it is certainly important that this new law be made to work.

Peer review is only effective when those involved approach problems with an open mind. The medical profession is one of the few, if not the only one, that consistently practices self-criticism. Accordingly, tissue committees and scientific and research activities have been established to seek better ways of approaching medical problems.

With the spotlight on the profession as it is today, it becomes the responsibility of the members to root out the small percentage of offenders that malign the medical field. Although this consists of only an estimated one half of one percent, with the help of the Commission on Medical Discipline, this can hopefully be reduced to zero.

John Sargeant



Legal Aspects of As They Affect

The Medical and Chirurgical Faculty, in cooperation with the Joint Medicolegal Committee of the Maryland State Bar Association, presented two sessions of a symposium designed as a continuing dialogue between the medical and legal professions to discuss a topic of mutual concern—malpractice suits. The first session was held in January 1969, wherein a panel of physicians presented their views on the medical aspects of malpractice suits for the Bar Association. In April, a panel of lawyers discussed the legal aspects of the problem as they affect the practice of medicine, before a similar group comprised, this time, of physicians. Included in the sessions were such topics as informed consent, record keeping, legal liability in the training and supervision of interns and residents, and the treatment of minors.

Judge George D. Solter, of the Supreme Bench of Baltimore City, introduced the physicians at the January session.

"This is the chance for the physicians to tell it like it is to the lawyers. Although it is in no way intended to be an argument in rebuttal, it is intended to present the viewpoint of the two professions on the subject of mutual concern.

"I can think of no more provocative subject for the two professions to discuss than the question of malpractice and its impact on the practice of medicine and, by virtue of the corollary, its relationship to the practice of law by negligence and tort lawyers. No greater question faces the two professions.

"As we all know, the increase of malpractice claims in recent years has been rather substantial. While it must be recognized that a physician be held civilly accountable for any neglect on his part in his practice of medicine, it must always be remembered that the lawyer has a duty to investigate, listen to, and study a potential malpractice claim before he pursues it, and make sure that his client's claim is in fact meritorious and actionable. The frivolous claim can cause irreparable damage to the physician, resulting in wasted time, money, and effort for the lawyer, and disappointment for his client.

"There are many reasons for the increase in the number of malpractice suits. It is hoped that during these sessions, these reasons will be presented and clarified, and that many pertinent questions on the subject will be raised and answered by the members of the two panels."

Malpractice Suits

the Practice of Medicine

Howard F. Kinnamon, MD, introduced the speakers for the second Medical-Legal session in April. Dr. Kinnamon is a member of the Faculty's Medicolegal Committee.

"This is the second meeting of the Medical-Legal group. This time we have a panel that will represent the legal aspect of the problem to members of the medical profession.

"Several important points which should be brought to light include the statement that no physician has really suffered as a result of a malpractice suit. Exceptions are such instances as the young physician who is presently suffering from a severe case of bleeding ulcers as a result of a persecuting malpractice suit.

"Although monetary damages are most frequently awarded to the patient, a certain percentage of the money is collected by the lawyer for his services to the patient.

"Another important point is the inequality that exists in the two professions. While a physician is expected to tell his patient of any possible problems or complications that may result from the physician's treatment of the patient (and this may lead the patient to seek another physician) a lawyer has no such problem. Not many complications would arise as a result of the patient's filing a malpractice suit against the physician, since the patient (and the lawyer) have nothing to lose, but all to gain.

"Also, there is another important difference here. If a group of lawyers (the Supreme Court, for example) reached a unanimous decision on an important issue, one would wonder. But if a similar group of physicians could not agree on the best course of management for a patient, certainly one would be most concerned.

"The physician should not be bothered by nuisance cases. Once again, the physician is faced with the responsibility of defending himself and his practice. Certainly, the physician does not deserve such persecution for such small-scale complaints.

"Since many physicians do not live up to their responsibility in setting the standards for their profession, it often becomes the jury's duty to do so. It seems that often a lawyer prefers to keep his problems with his client within a jury so that he does not have to go to a panel of physicians for an opinion. What does the lawyer have to lose by allowing the patient to come to the medical profession for an opinion?"

The following papers were presented during the January and April 1969 sessions of the Medical-Legal Symposium.

From the Physicians' Point of View . . .



MALPRACTICE

from the Private Practice and Institutional Psychiatric Viewpoint

JOHN M. HAMILTON, MD
Superintendent
Clifton T. Perkins State Hospital
Jessup

There was a time when all of the fears and concerns about physician malpractices could be conveniently stored in the stock phraseology learned by every medical student in a course possibly labeled "Medical Jurisprudence 101". This phraseology generally went something like, "A physician may not be considered negligent or otherwise guilty of medical malpractice if, in the course of his examination and treatment, he demonstrates that he has acted up to a standard of performance of the reasonably prudent physician licensed to practice in his community." Malpractice has subsequently become a much more complex area of concern and, just how much more complex, is indicated by these two examples which are quoted verbatum:

"Civil Suit Won in Murder Case: Psychiatrists Ruled Negligent [1]

"An unusual compensatory damages award, which may have far-reaching consequences in the question of psychiatrists' responsibility for their psychotic patients, has been made in a federal court in North Dakota.

The court ruled that two psychiatrists and a psychologist at the Veterans Administration Hospital at Fort Meade, S.D., had been negligent in failing to control a patient who subsequently murdered his wife.

Testimony in the case indicated that Mr. William B. Newgard was committed to a state mental hospital in January 1965 and later transferred to the Veterans Administration Hospital. Authorities permitted him to leave the hospital on one occasion to attend a funeral despite objections by the patient's wife, who feared harm from him. She had him seized and returned to the hospital.

Subsequently, hospital authorities decided to find work for the patient outside the hospital in preparation for his release. Again his wife objected, in a telephone conversation with a staff psychiatrist, contending that the patient was dangerous. However, the hospital completed the arrangements for outside work, although it claimed that it had restricted the patient's movement so that he could not see his wife. Shortly after beginning work, the patient drove to his former home and shot his wife to death.

Suit was brought in federal court by the administrators of the wife's estate on behalf of her children, charging the hospital with negligence. The court, sitting without a jury, awarded $200,000 to the estate.

U.S. District Judge Ronald N. Davies ruled that hospital authorities were negligent in a number of actions and omissions. A psychologist was found to have failed to exercise reasonable care by not making certain that the outside employer was aware of the circumstances and the need for restrictions on the patient's travel and activities. The employer had testified that he had assumed that the patient was free to come and go as he chose.

The psychiatrist who had spoken with the wife when she telephoned to object to the patient's impending release was found negligent for having failed to make notation of the call and for having failed to pursue the matter further.

Another psychiatrist, who had treated the patient and conferred with his wife on several occasions, was found to have "ignored and rejected every warning signal" that the patient was dangerous and that the patient's wife "had every reason to be in mortal fear of her husband." The court commented that "had (the psychiatrist) devoted more of his time and talents to Newgard and less of them to diagnosing Newgard's wife, conceivably she would never have met so tragic and untimely a death."

A Fargo, N.D., psychiatrist commented to PSYCHIATRIC NEWS that the case "would appear to set a precedent" for the ways in which employees of the hospital were found negligent. The Veterans Administration is expected to appeal the ruling."

"$200,000 Award Points up Widening Malpractice Liability" [2]

"A $200,000 malpractice award by a White Plains, N.Y. jury has far-reaching implications for all physicians, according to medicolegal experts. For one thing, it demonstrates a fact many practitioners may not know: A doctor can be held liable for an injury to someone he has never treated.

Another unusual aspect of the case was the type of malpractice charged—failure to restrain a mental patient. Such accusations have become increasingly frequent in the past three years and, the experts believe, could well be brought not only against institutions and psychiatrists, but against other doctors as well. In addition, the amount of the award is a warning to doctors, particularly in rural areas, to review their malpractice insurance coverage.

The White Plains case involved Silvio Provenzano, who had been committed to Grasslands Hospital, a county institution, as a paranoid-schizophrenic after having been charged with assaulting his wife. Following an uneventful stay at Grasslands, Provenzano was transferred, at the request of his family, to Halcyon Rest, a nearby private hospital. After four months unmarked by incident, he was discharged.

In the meantime, Provenzano's wife had obtained a court order requiring her husband to support her. When he defaulted, she retained Joseph A. Vassalo, a Harrison, N.Y., lawyer, to collect. Vassalo contacted Provenzano soon after his release from Halcyon Rest, and Provenzano agreed to meet him to work out details for payment.

Lawyer Bitten by Defendant: At the conference, attorney Vassalo later testified, Provenzano appeared normal. Then, without warning, he suddenly leaped across the desk, seized the lawyer with both hands, bit off the lower half of his nose, and fled. Provenzano was later convicted of assault and battery and was sentenced to three years, most of which he served in the prison hospital.

Meanwhile, Vassalo brought a malpractice suit against Grasslands, Halcyon Rest, and Dr. Alexander Carlen, Provenzano's psychiatrist at Halcyon, charging all three defendants with failure to confine and supervise a dangerous mental patient. As a result, the suit claimed, Provenzano had been free to come to Vassalo's office and, in the words of a medical expert, cause "a traumatic amputation of the lower half of the lawyer's nose."

By the time of the trial, Vassalo had spent eight months in various hospitals, had undergone ten plastic-surgery operations on his nose, and had incurred $22,000 in medical bills. Although he admitted the cosmetic result was as good as he could have expected, he testified that he had no feeling in the nose and often could not breathe properly through it.

In addition, Vassalo charged that the incident had harmed his law practice, social life, and family relationships. Also, because he lived in a small town, he argued that his personal suffering and humiliation had been intensified—to the amount of a quarter of a million dollars, he urged upon the jury.

After the trial judge had ruled valid Grasslands' defense that it could not be held responsible for a patient who had been transferred to another accredited hospital, the jury brought in an award of $200,000 half to be paid by Halcyon Rest and half by Dr. Carlen. The trial judge refused to set the judgment aside, and neither defendant appealed the decision.

Vassalo was never a patient of Dr. Carlen, was never confined to Halcyon Rest, yet he successfully sued both. Still the case is not unique. Many courts have held physicians liable if their failure properly to diagnose infectious disease, for example, has caused uninvolved third parties to contract it. And mental institutions have often been adjudged negligent for failure to restrain or supervise patients. But the Vassalo case marks the first time that a private practitioner has been liable for injury inflicted by his mental patient."

These examples indicate the broadening base from which malpractice suits are contemplated and adjudicated. The indications are that both the private practitioner in psychiatry, the psychiatric administrator of a hospital facility, and psychiatric and general hospital staff physicians have to take much more care in the management of their practice and the carrying out of institutional responsibilities in order to meet the reasonable expectations of the community in relationship to quality as well as quantity of medical care.

In this presentation, I intend to cover, meaningfully, malpractice implications as related to psychiatrists' responsibilities both institutionally and in private practice:

1. relative to patients' records—privilege and confidentiality;
2. permission in procedural examinations and treatments, and informed consent;
3. institutional and office safety standards—patients' and employees' injury;
4. psychiatric emergency and the medical emergency in a psychiatric setting outside the general hospital;
5. delegated responsibility for patient coverage by the private practitioner, and in institutional coverage settings;
6. standards of medical care as reflected in anticipated court prescription and supervision of psychiatric evaluation and treatment;
7. the area of clinical judgment as reflected in the disposition of the dangerous or suicidal patient regarding his release or detention, and the probable liability implied, and death—the institutional and private practice responsibility.

Patients' Records—Privilege and Confidentiality

I have purposely begun with a priority devoted to the hospital or institutional medical record and the private practitioner's record of examination and treatment because so much of what is subsequently validated and adjudicated depends upon the accuracy, appropriateness and adequacy of documentation, and the manner in which the physician or institution guards patient privilege and confidentiality. I can quite well remember how the importance of records was impressed upon me by my clinical professor in obstetrics and gynecology, who had two general administrative maxims in the administration of his department; both of which go to the heart of general malpractice matters we are discussing today, and one of which is particularly meaningful in the area of records. In many conferences in the department, I, along with other residents, would frequently describe procedures which had been done and the results which had been achieved only to have the professor call for a look at the record, following which we would receive a lecture revolving around why we had not reduced this previous recitation to writing. His maxim about this was simply, "work not written is work not done." In essence, this is the importance of records. We have little to fear in the malpractice area, generally, if we have meticulously prepared written accounts of our professional behavior in relation to the particular patient involved. Records should serve to reliably account the history, findings, diagnosis or diagnoses, and the prescribed treatment along with the follow-up response to treatment, and a documentation of any significant events which occurred in the realm of the private practice supervision of the patient, or in the realm of his hospital management. The language used should be the language which properly portrays the full meaning of our evaluative and treatment interventions, with all of the relevant variables indicated and described.

There are several kinds of records which are a part of the official institutional medical record in a psychiatric setting and, of principle concern to us are those records validating the commitment status of the patient (commitment certificates, court orders, requests for commitment and treatment of a voluntary nature, etc.); psychiatric and social case studies, psychological tests, protocols and interpretive reports, special clinical and laboratory test reports and tracings; identification data; progress notes by medical and nonmedical staff; special incident reports; staff conference notes and summaries; discharge and dispositional summaries; etc. It is important that the compilation of these reports represents no essential conflict of vital information. It is also important that the recorded information is as accurate as can be circumstantially possible. All conclusions, interpretations, diagnostic and dynamic formulations, and treatment prescriptions should be soundly based on objective findings relative to the particular patient involved. Speculations, which are unfounded in sound psychiatric knowledge, and specific findings, relative to the patient at hand, should be assiduously avoided.

There was a time in our state when the patient privilege between psychiatrist and patient was not protected by statute. This has recently been statutorily corrected and psychiatrists in private practice, who had previously denied the existence of records for legal purposes, can now admit that they have them without fearing abuse. There are some conflicting views, however, about the general extent of patient privilege and, to just give you extremes, I cite two decisions:

"Calling Psychiatrist as Witness Waives Privilege" [3]

> "In a prosecution for armed robbery in which the defense of not guilty by reason of insanity was raised, a trial court properly permitted a psychiatrist to testify as a rebuttal witness for the prosecution, over the accused's objection of vio-

lation of the psychiatrist-patient privilege, an Illinois intermediate appellate court ruled.

The accused called as a witness in his behalf a psychiatrist who had examined him two weeks before the crime. He stated the opinion that, on the date of the crime, the accused lacked the ability to appreciate the criminal nature of his act or conform his conduct to the requirements of the law. The prosecution then called as its witness a psychiatrist who had examined the accused at about the same time as the accused's witness, as well as three months earlier. The prosecution's witness stated the opinion that the accused was legally sane at the time of the crime.

The prosecution had the burden of proving that the accused was sane at the time of the crime.

By calling the psychiatrist to testify in his behalf, the accused waived the psychiatrist-patient privilege as to the psychiatrist called by the prosecution.—*People of the State of Illinois v. Givans,* 228 N.E.2nd 123 (Ill, May 8, 1967)"

"Insanity Defense Not Waiver of Physician-Patient Privilege" [4]

"In a prosecution for murder in which the defense of insanity was raised, a trial court erred in permitting a psychiatrist who had treated the accused at a state mental hospital after the offense to testify as to his sanity, the Minnesota Supreme Court ruled. The conviction was reversed and the case remanded for a new trial.

Following the killing, the accused was examined and found to be in a state of insanity which made him incapable of understanding the criminal proceedings against him and cooperating in his defense. He was committed to a state mental hospital.

When he regained his sanity, he was brought to trial. Over the accused's objection, based on the physician-patient privilege statute, the psychiatrist who had treated him at the mental hospital was permitted to testify that, in his opinion, the accused was legally sane at the time of the killing.

The physician-patient privilege statute makes no distinction between "public" and "private" physician-patient relationships, and no reasonable basis exists for making such a distinction. It is the patient who is the beneficiary of the privilege, and it should make no difference whether he is a "private" or a "public" patient. This is especially true with respect to state mental hospital patients, where complete confidence in the attending physician is indispensable to the cure.

The accused did not waive the privilege by asserting the defense of insanity or by presenting the testimony of four physicians who had treated him before the killing. The four physicians expressed doubts as to his mental capacity but had no definite opinion as to his legal sanity. The statute clearly provides that a physician shall not disclose without the patient's consent any information or any opinion derived from the patient while attending him in a professional capacity.

The accused refused to submit to an examination by a psychiatrist for the purpose of qualifying him to testify as an expert witness. He had the constitutional right to refuse to submit to such an examination. His refusal to submit to an examination and his consistent objections to the psychiatrist's testimony completely refuted the giving of consent, either express or implied.—*State of Minnesota v. Fontana,* 152 N.W. 2nd 503 (Minn., July 28, 1967)."

Permission in Procedural Examinations, Treatments, and Informed Consent

Most private practitioners and most institutions have for many years extracted from patients, or responsible relatives, blanket permissions to engage in a universality of evaluative and treatment practices. Malpractice suits have caused quite a departure from this relatively well-established policy in most institutions. Now, most of us require special permission forms approving each individual evaluative or treatment procedure if it involves anything that may, in the least, be considered potentially dangerous or harmful as a side effect in its achievement. We are all familiar with the extent to which a practitioner's malpractice insurance premium rises with his involvement in the special procedure area. A psychiatrist who either administers electroconvulsive treatment, or supervises its administration by staff physicians, or residents, generally has a substantially higher premium rate than one who does not. This, of course, brings in a sidelight of the extent of a physician's responsibility when one is involved in a supervisory capacity—administratively or in a teaching supervisory capacity—and how this affects his personal liability for what happens to patients under the direct care of those supervised. It would seem that, currently, to be on the "safe side," physicians in administrative and supervisory functions have to be extremely concerned about the nature and quality of their interventions as it directly affects the care of patients.

For those of us who are at work in institutions where federal assistance, grants, or fellowships provide financial support, we are all too familiar with the essential ingredients of informed consent. We have been required, in the area of federal fund participation for research and treatment programs, to indicate that we will universally deal forthrightly with patients in regard to informed consent. This means that prior to a patient's approval of his participation in a particular examination or treatment, he must have explained to him the possible, as well as the probable, outcome of the examination or treatment procedure

and it must be ascertained by the treating physician, or his delegatee, that the patient understands that about which he has been informed.

Institution and Office Safety Standards—Patients' and Employees' Injury

We are all familiar with the general safety standards which the Joint Commission on the Accreditation of Hospitals has approved under its codes for institutions, and we are familiar with the general office standards which are imposed upon us by insurance companies that write liability insurance for personal injury. The increase in malpractice suits and judgments against institutions and individuals in this area seems to have caused institutions and individuals to adhere to a safety standard of excellence which might be beyond reproach. This has been, I think, a valuable outgrowth of the many malpractice cases in this area, though for some institutions it has added considerable operational expense, in the form of inspectors and maintenance of personnel, to achieve and maintain the degree of safety required to insure against personal injury of both patients and employees.

Psychiatric Emergency and Medical Emergency in a Psychiatric Setting Outside the General Hospital

In a psychiatric setting, where physicians, both trained and untrained, are primarily psychiatrically oriented, there is a danger that the basic physician identity may be somewhat sub-tended by one's interest and concern in the speciality area. To this extent, the psychiatric practitioner may be tempted to become lackadaisical and cursory in his application of standard and generally accepted physical-medical principles to the psychiatric and medical emergency which occurs in an area for which he is responsible, or to a patient in his care. Though most psychiatric hospitals provide proper medical speciality care by qualified consultants, or even full-time staff members, these persons are not always at hand to manage the emergency. The fact that one is a psychiatrist does not relieve one of general medical responsibility, as long as one is a licensed practicing physician, especially when an emergency situation arises.

Delegated Responsibility for Patient Coverage, etc.

Physicians generally have, long ago, discovered the advantages to be reaped in involving themselves in group practice with other members of their particular medical speciality, as well as with those of diversified specialities. This insures that, upon one's absence, patients are left to the care of competent practitioners in whose judgment one has some faith since one's responsibility is likely to continue, even during the period of absence, under many jurisdictional rulings. The problem of proper patient coverage, then, is a significant one both in private practice as well as institutional practice. The burden of responsibility of patients' medical care and their behavior while under treatment, either as an outpatient or as an inpatient, is a relatively tremendous one which has many pitfalls. Institutional coverage circumstances are particularly suspect in this area. It is the usual practice in psychiatric settings to have a full staff of physicians available during what is termed the administrative day, which might last anywhere from 7:30 AM to 5:00 PM, and variations of these hours of coverage; and, to have Officers of the Day or Night Duty Officers responsible for the patients in the setting for the remainder of the hours. Often these physicians are not actually physically present during the off-hours and may, in some instances, only be reached by phone in case of an emergency. Numerous problems have arisen in this gray area of medical coverage responsibility. I foresee the day when either malpractice pressures, or the supervisory pressures of the court, unsolicited by malpractice endeavors, will change our administrative practice and philosophy in this area.

Standards of Medical Care as Reflected in Court Prescriptions, etc.

The courts in certain jurisdictions have become extremely interested in the level of medical care as purveyed particularly to patients who are housed in psychiatric settings. The critical question seems to be whether patients in such settings are primarily deserving of a particular standard of treatment as a right, or whether this is a privilege to be given to some and denied others, either whimsically or for some other reason. The United States Court of Appeals for the District of Columbia, where Judge David Bazelon is the Chief Judge, has been particularly outspoken in this area recently. The following is an excerpt from a case:

> **"Rights of Mentally Ill Patients"[5]**
>
> *"Mental Hospital Patient*
> *Entitled to Adequate Treatment"*
>
> "A man involuntarily committed to a mental hospital, after being found not guilty by reason of insanity of a charge of carrying a dangerous weapon, had a right to adequate treatment, the U.S. Court of Appeals for the District of Columbia Circuit ruled. The right was held enforceable by means of habeas corpus.
>
> The Hospitalization of the Mentally Ill Act specifically provides that a person confined to a public mental hospital is entitled to medical and psychiatric treatment and care. That provision applies to all patients, without regard to the statutory authorization for their commitment to the hospital.
>
> The trial court had refused to consider the pa-

tient's contention that he was receiving no psychiatric treatment at the hospital, ruling that its jurisdiction was limited to the determination of whether the man had regained his sanity. The appellate court remanded the case to the trial court for a hearing on the adequacy of the care and treatment being furnished to the man by the hospital.

The hospital would not have to show that the treatment being provided would cure or improve the man's condition, but only that a bona fide effort to do so was being made. Thus, the hospital would have to show that periodic inquiries were made into his particular condition and needs and that he was provided with treatment suited to the condition and needs. The treatment provided should be adequate in the light of present knowledge. A continuing failure to provide suitable and adequate treatment cannot be justified by lack of staff or facilities. —*Rouse v. Cameron,* 373 F,2d 451 (C.A., D. of C., Oct. 10, 1966; as amended, April 4, 1967)."

It would seem that institutions which indicate that their existence is a therapeutically rehabilitative one, rather than a custodial one, will be forced to demonstrate an acceptable standard of excellence in delivering proper evaluation and treatment.

Area of Clinical Judgment as Reflected in Anticipated Court Prescription, and Supervision of Psychiatric Evaluation and Treatment

Near the beginning of this presentation, I quoted a case which resulted in a $200,000 malpractice award in which psychiatrists were ruled negligent because of certain errors of omission and commission reflecting upon their clinical judgment in the management of the potentially dangerous patient. This is an extremely nebulous area and may well turn out to be the most important malpractice area in psychiatric practice. Just how much can be expected of the clinical practitioner as a predictor of human behavior cannot be clearly outlined with our current level of psychiatric knowledge; yet, in an area where the guidelines are so unclear, we are likely to be held 100% responsible. The institutional death, either from natural causes, self-inflicted or the result of attack by other patients, or injury, always presents a problem. This leads us full-circle back to the beginning of the presentation and the responsibility for accurate and reputable report of incidents and circumstances surrounding whatever transpires relevant to a patient's management while institutionalized. The successful suicide of an inpatient, or an outpatient, is the cause for particular concern since this is an area in which our relevant prediction is good, but our ability to prevent remains relatively poor.

Conclusion

I have sketched briefly some of the many areas of administrative and private practice concerns in the matter of malpractice liability. Though space has not permitted a comprehensive development of all of the sub-topics, it is my hope that bringing them to your attention has proved informative and provocative.

REFERENCES

1. American Psychiatric Association, *Psychiatric News,* **Vol. III,** No. 2.
2. *Medical World News* (issue unknown)
3. Excerpt from THE CITATION, **Vol. 16,** No. 9, Feb. 15, 1968, pg. 138-American Medical Association.
4. Excerpt from THE CITATION, **Vol. 16,** No. 9, Feb. 15, 1968, pg. 139-AMA.
5. Excerpt from THE CITATION, **Vol. 16,** No. 9, Feb. 15, 1968, pg. 134, AMA.



Perfection Of Standards, And Informed Consent In Preventing Malpractice Suits

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To illustrate the impact of medicolegal decisions on the practice of medicine, I can think of no more vivid case than one tried a decade ago in Ireland. The plaintiff was given a spinal anesthetic for surgery. Subsequently, there was temporary residual neurological damage to the bowel and bladder. The plaintiff sued and recovered. Since that case, virtually no spinal anesthesia has been given in Ireland. There, the patient is no longer afforded the full medical services of the anesthesiologist. There are no more saddle blocks for obstetrical delivery. There is no more spinal anesthesia for the poor-risk patient needing emergency surgery, such as the patient who has just eaten, or the patient who has had a recent myocardial infarction, in whom the mortality rate approaches 100%. In Ireland, the anesthesiologist feels that he hasn't a fair chance with the law.

In the case cited, spinal anesthesia was not proven unsafe, for indeed, if properly used it is not. It was not proven that the defendant used the technique improperly; rather, there was testimony from the surgeon present that the technique was ordinary and responsible. The evidence in this case was based on possibility. Evidence was introduced stating that the soaking of the anesthetic solution ampule in carbolic acid in order to sterilize it possibly could have led to an influx of the carbolic acid through a minute pore in the glass ampule into the anesthetic solution, thereby poisoning it. This contamination would not be detectable by visual inspection, nor by any ordinary means. The anesthesiologist was told that day that ordinary prudence wasn't good enough; any damage resulting from his act would make him liable, and that the act of performing a standard procedure would render him at peril for all consequences following thereafter. And so the standard of care was elevated to near perfection and damage was presumptive evidence of negligence.

We physicians feel that proximate cause must be retained in the proof of malfeasance and must be the crucial point in the trial. The other essentials, namely the duty owed to the patient and the damage, are already self-evident, and we are seeing the erosion of the law when the emotionally charged area of the patient with damages is adjudicated. We ask only that negligence be proved, not imputed.

The Physician's Responsibility

A secondary area of controversy is the responsibility of the physician to inform the patient. Failure to inform the patient of his diagnosis and the consequences of that diagnosis constitute a cause of action for malpractice, if damage follows. There is no argument to this basic medicolegal responsibility. To what extent, however, is this duty to inform to be extended? Many decisions have shown us that there is no limit to the detail that is required of us legally. It is apparently not enough to make a diagnosis and prognosis, and then to so inform the patient. The decisions illustrate that we must inform and, indeed, warn him of all complications, even the most unlikely, that follow our course of treatment. In the field of therapy or anesthetic administration, we are especially liable, for here we are doing something to the patient. When we actively do something and damage follows, the patient naturally says, "If I had known this could happen, I never would have consented." We are then defendants in a suit because we failed to inform the patient of all of the complications of anesthesia. It reminds me of the wise old farmer who always said that if he knew where he was going to die, he'd never go near the place. If I were to make rounds and to adhere to my duty to inform, carried to what I consider an extreme, it may go something like this:

"Good evening Mrs. X. I am Dr. Y., an anesthesiologist. The nurse tells me you are somewhat apprehensive about your forthcoming anesthesia tomorrow. I hope that I can answer your questions and reassure you that from our viewpoint everything looks fine for tomorrow. I will tell you exactly what we are going to do so there will be no mystery. I will give you several pills in the morning that will take the edge off of your nerves. You will then be brought to the operating room where I will see you. We will put a blood pressure cuff on your arm and a needle in your vein. I will put you to sleep with thiopental (*Pentothal*). After you are asleep, I will paralyze you with arrow poison curare, and place a tube in your windpipe. I will then use cyclopropane, a general anesthetic, to keep you anesthetized throughout the operation. As you know, you are having your stomach removed, so I will breathe for you throughout the operation, which usually lasts 3½ hours. General anesthetics depress your heart appreciably, affect your liver adversely from three to five days, and halve the blood flow to your vital abdominal organs. The chance of part of your lung collapsing varies from about 10% to 40%, depending upon the literature that you have read. During the operation, I will have to decide how much blood and fluid to give you. Usually, two pints of blood and two quarts of solution are required. At the end of the operation, I will give you some potent medicine that temporarily poisons your enzymes so that arrow poison will no longer be effective. After getting you to breathe on your own, I will remove the tube from your windpipe and make sure you don't stop breathing because of airway obstruction. I will then take you to the recovery room and give you potent pain-killing drugs to prevent your vomiting. I hope by explaining my responsibilities I have set your mind at ease and that you will sleep well tonight."

Even then, I have not told her the risk of each drug, the danger of air embolism, or the possibility of death from vomiting and aspiration of stomach contents, the danger of explosion from the anesthetic; so that I have not really informed her. Literally, I could go on for hours informing her of all the possible complications which might occur.

Informed Consent

You know, it is a good thing that informed consent is not expected of the airline pilot. When we get on an airline and fly to the Pacific Coast, the pilot does not come over the intercom and relate to us all the dire possibilities that may happen during the flight. We are presumed to know that air flight is safe but that planes do crash. We are presumed to know, and we think that our patients know that anesthesia is safe in general, but that there are com-

plications and morbidity and mortality. We feel that they have agreed, either expressly or impliedly, to place a trust in your ability to land safely, as far as the anesthetic venture. Many patients do not want information. We come in contact with a large group of patients who, when we walk in the room, tell us, "Don't tell me a thing. I don't want to know anything about it. Do what you have to do. I just want to be asleep." Gentlemen, we want the same law applied to us that is applied to other persons charged with the lives of others.

I have been told by many attorneys that the operative and anesthetic consent is not worth the paper it is written on. We wonder why this should be. Why can't a general consent for surgery to be performed and the anesthetic to be administered be valid, if the patient so agrees. Instead, every attempt is made at trial to show absence of consent because every detail was not presented to the patient. We ask that our operative permits be respected legally. If there be fraud in obtaining them, then let it be shown and the fraud will avoid the consent. But fault should not be found with the physician who obtains the permit in good faith. We ask, then, that our operative permits be construed strictly so that, again, he who consents cannot be legally wronged.

Rising Medical Costs

The impact of decisions on the cost of medical care is considerable. I shall briefly mention several examples. In the operating room, we see medically needless X-rays of surgical operative sites—medically needless, but extremely necessary in the eyes of the surgeon. The X-ray is his only objective defense against a malpractice suit, should damage ensue. He is practicing defensively rather than as a free agent. This delay in the operating room is passed along to the patient as increased X-ray fees, operating room fees, and anesthesia fees, and perhaps even increased morbidity and delayed convalescence. If we could stop practicing preventive law, we could lower the cost of medical care considerably to these patients.

In the State of California, my colleagues in radiology inform me that deep X-ray treatment of cancer is all but nonexistent except in the large medical centers. The hardship of a cancer patient having to make repeated long trips for treatment at the major centers is unnecessary. But to the therapeutic radiologist, the legal hazards of administering high voltage treatment are such that only the state institutions can afford the legal consequences. The result of legal decision, here again, has told the therapeutic radiologist that he is in danger when using such an instrumentality.

The medical liability of the pharmaceutical manufacturers has resulted in a distinct detriment to sound drug therapy. Current brochures which accompany a given drug are given more legal weight, as evidence in a court of law, than the judgment of specialists or pharmacologists using the drug. Such brochures are loaded with absolute, relative, and ethereal contraindications such as; Drug X may be contraindicated in certain cases of possible liver disease. Such a warning is medically meaningless but is devastating on the witness stand when read to the jury in a damage case. Such brochures have been worded so as to remove any liability for breach of implied warranty by the manufacturer. If aspirin were an investigational drug at present, it would take about three years to be cleared by the Food and Drug Administration. Its brochure could say that it redisposes to gastric irritation, peptic ulceration, bleeding tendencies, and metabolic acidosis, all of which are true. In addition, 50 persons die in the United States each year from aspirin anaphylaxis. So even the safest drug is not without lethal potential. There is no way for the physician to know what the results of a given drug to a given patient will be. To hold him liable for rare or abnormal responses to a drug is punitive indeed. Yet, this is the position we find ourselves in. Because we are the ones who started doing something to the patient, it all seems to rebound to us, whether damage, indeed, is shown or not.

Conclusion

Space obviously does not permit discussion of the locality rule, *res ipsa loquitur*, or the reluctance of specialists to delegate responsibility to their agents—and this is a pressing problem—the nurse anesthetist, for example. Time has not permitted the discussion of the beneficial effects of law upon medical practice. We have mentioned only several broad areas of controversy in hopes of stimulating further thinking and understanding. And although it may sound as though I am overcritical of the law relating to medical practice, nothing could be further from the truth. The body of Anglo-Saxon common law which we have inherited and modified to fit the new world is, in my opinion, the greatest collection of equity the free man has ever known, and the legal profession is the guardian of that body of law. We physicians ask only that these legal principles be construed strictly as relating to medical practice so that remote cause does not come to replace proximate cause in tort actions; so that the operative permit is indisputable evidence of consent; so that damage is not presumed to be negligence; so that the physician is not held to a standard of care of near perfection, but is held liable only as the mortal scientist and practitioner that he in fact is.

This is an age of progress,

an age of hope.

It is an exciting time.

Truthfully, we as a society

have accomplished more in the past 25

or 30 years than in all of recorded history.

THE IMPLICATIONS

But, one of the fundamental problems

that faces our society today is

our inability to put technological advances

on a par with human advances,

and, as a result, we are faced with the problems of medical malpractice.

Malpractice is simply a consequence of our inability to keep up with technological progress.

OF MALPRACTICE SUITS

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Malpractice is not all bad, and it has brought about some beneficial results. First of all, there is a far wider dissemination of knowledge today than ever before, and consequently, the patient is better informed than in the past. He is now participating more in the care that he receives. Today's patient wants a physician who is involved in his care and treatment, and we as physicians, as professional people, must involve our patients in the care that we render. The physician as an overprotective father image of the past does not belong to today's world. Our problem as physicians is our failure to recognize that our patients are so informed.

Also there is a much greater emphasis on professional competence today. Malpractice, either directly or indirectly, has led many of us physicians to attend medical meetings. It has forced us into a greater realization of our responsibilities as professional people. It has made us more aware of our ties to our professional organizations, and to be a member of these professional organizations implies, and indeed almost requires, increased competence.

Certainly, malpractice has been a boon to preventive medicine. Today, I can say to my patient, "I suggest and advise you to have a certain series of X-rays." She says, "Well, doctor, I can't afford it; I don't want to do it." I could say, "Okay, I can only advise you; you have to do it; you have to make an effort; I will make the arrangements." And she may say, "Well, I don't want to do this." Again I say, "Well, I will write it down here in the note, and if something happens six months from now, you can't come back and say I didn't warn you." This causes many people to take the care which they would otherwise not take, because frequently when it becomes the patient's responsibility, he will accept it. We are no longer the father figures of the past.

So much for the good. What about some of the bad aspects of malpractice? No doubt our patients are exposed to greater anxiety. This has already been clearly pointed out. But, I have also learned from my dealings with people that with a little time and some sincere cooperation, this fear can be greatly allayed. It does force the patient to make more decisions. When he just cannot make these decisions, the physician must force him to do so.

Malpractice has also caused increased suspicion of our system of medical care, and has helped bring about the increased cost of medical care. As for those of you in the legal profession, you must share with us the burdening and increasing role that cost is playing in patient care. You can no longer place all the blame for rising costs on the physician. Every facet of our society is directly or indirectly responsible for the rising cost of medical care.

As for informed consent, I much prefer to see a patient in my office, examine him, listen to his complaints, form an opinion of his condition, have him return to my office to discuss his problem, make a recommendation to him, and then, if the condition requires surgery, perform it to the best of my ability. As far as certain technical problems that may arise, such as indispensable nerves or arteries, I tell the patient that there may be an injury or another unexpected result, but that I will be as careful as possible. Thus, I have informed the patient, but at the same time I have assured him that, as his physician, I am going to do the best within my power.

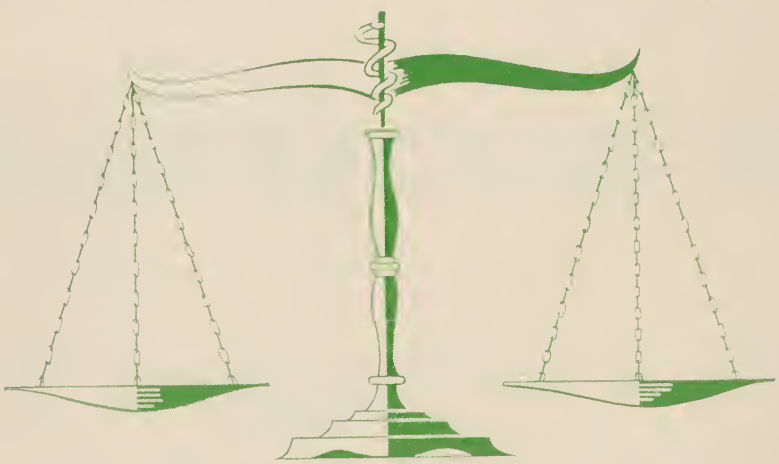
Residency training is a real problem, and the legal profession shares this problem. However, with a patient's initiative, and insurance companies and governmental help, almost all citizens in this country can get good health care, regardless of where they go. This is not the real problem. The real problem that confronts us is the shortage of human clinical material to train physicians and surgeons to deliver adequate health care for the patients of the future. The general public must come to understand and appreciate the capabilities of the resident or intern who is training under the supervision of a competent physician. The concept of team surgery must be strengthened, and the importance of all members of the team must be stressed. This is the only way that we are ultimately going to be able to provide the necessary quantity and quality of physicians to meet our future needs.

What are some of the other impacts of malpractice on medical practice? Malpractice is certainly discouraging young men from entering the private practice of medicine. This is one of the greatest tragedies of our time. The corner physician hardly exists anymore. Patients are now being forced into emergency rooms, being forced into a mere numbers game. Many young men are literally afraid of taking on the responsibility of a private practice.

Medical Economics said that in 1969, one in every six physicians would have a malpractice suit filed against him. No wonder we are losing students to other disciplines. We as physicians are raising our standards of medicine much too high.

Even though the question of malpractice results in unnecessary red tape, it has also brought with it a deeper awareness of the value of medicine, for both the physician and the patient. So, the current challenge lies in being able to prevent malpractice from occurring, and in protecting those physicians who are unjustly accused. This can be done by gaining a better understanding of the bills introduced into the state legislature so that we can set definite guidelines, not only for the physician, but also for the patient and the lawyer as well.

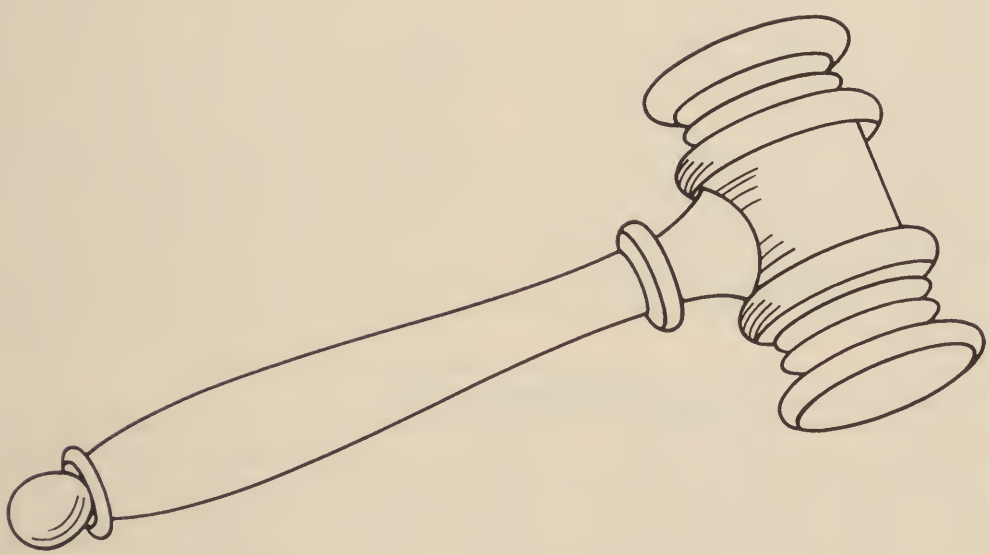
The Lawyers Speak . . .



MALPRACTICE IMPLICATIONS

and the Safeguards in Maryland's Law

JUDGE W. ALBERT MENCHINE
Third Judicial Circuit of Maryland



What appears to be a major problem in discussing the issue of malpractice suits against physicians is the question of whether or not the physician is presented with an accurate picture of the law that governs and controls this litigation. Too frequently, physicians are presented with statements of the pros and cons of the problem—arguments by their advocates, or representatives—that are not the law.

One of the great fears of a physician confronted with a malpractice situation is that the threat of suit, or the filing of suit, will be damaging to his career. As far as I am aware, there has been but one empirical study of this question, the result of which is recorded in the Journal of the American Medical Association **of July 1, 1961. The inquirer included every concluded case in the State of Connecticut over a 25-year period. Cases involving both successful and unsuccessful litigation against physicians were included. The following is an excerpt from the reported study:**

> **"Objectively, the effects of a malpractice suit upon a physician appear to be much less than generally believed. Not one case was found of a physician compelled to give up his practice, and move. No physician lost his license. None were ejected from hospital privileges, staffs, or societies. None were unable to obtain malpractice insurance, although a handful had to switch companies and pay higher rates. None claimed to have suffered professionally, and none suffered socially.**
>
> **"Almost as many reported that their practices improved, as those that reported their practices were injured. In no instance was there a claim that a practice was injured for more than two years. And in these instances, the doctors expressed no dismay at the reduction in their work load. No physician reported any personal financial loss, as the result of a malpractice suit. It would appear that the greatest damages to the doctor who is sued for malpractice are subjective in origin, and it is sincerely hoped that this study of the experience of physicians in Connecticut will provide a reliable standard of what the doctor can expect from a malpractice suit, and will indicate to the medical profession, as a whole, that a view of the malpractice suit has been taken which is too pessimistic. It is my hope that this study will reduce the ethereal to the concrete which can be realistically, honestly, and confidently appraised and mastered."**

This is a report in a distinguished medical journal. It is in accord with my own views—there is not the stigma attached to malpractice cases that physicians think there is.

The courts in many states, and the authors of many articles in many law reviews, have spoken of what is called the "conspiracy of silence". I don't really believe that it is a conspiracy, in any legal sense. Rather, it is a feeling of empathy that the physician feels toward the person who is accused of being negligent in his practice. I suspect that it really stems from an idea of "there, but for the Grace of God, go I". But there can't be any question that it is practically impossible, except in rare instances, for a person who claims that a physician is negligent to obtain the advice and help of members of the medical profession as witnesses in the litigation. Call it empathy, call it a conspiracy of silence, it is there.

The literature of the law makes it clear that certain developments have occurred, and can be expected to continue to occur unless there is recognition by physicians of their responsibility in the area of malpractice suits; that it is morally wrong *not* to testify in favor of plaintiffs, when it is established that negligence exists. (There isn't any doubt that baseless suits against medical practitioners ought to be contested to the very end.) There is nothing more discouraging to a lawyer in the filing of litigation than to be undertaking a hopeless cause in which his labors are futile. Cases of this kind are usually undertaken on the basis of a contingency fee—payment if successful, nothing if unsuccessful.

Legislatures are trying to find some way, other than the testimony of the medical witness, to present the cause of an injured individual who charges negligence. Massachusetts and Nevada, for example, have statutes that permit authenticated articles from medical periodicals, written by established experts in the field, to be presented as evidence to prove the negligence of a physician. Statutes such as these will probably increase in number unless the medical profession undertakes a more active role of "exposing the uneducated, ignorant, and incompetent doctor, who turned loose on a helpless community, is as deadly as a pack of artillery."

There is a growing tendency to permit general practitioners to testify in specialist fields. There is also a growing tendency of the courts to expand the doctrine of *res ipsa loquitor* to extents which courts of two generations ago would not have dreamed. The geographical area of expertise is also enlarging.

In some cases involving particular types of alleged malpractice, the brochures of drug manufacturers are admitted as evidence, of the proper way to administer a drug, as bearing upon the issue of negligence of the physician. The appellate courts of New Jersey, Kentucky, Wisconsin, and California have used the expression "conspiracy of silence" in connection with decisions upon medical malpractice cases.

Maryland is a conservative state in this area. The law of Maryland, that deals with the alleged neg-

ligence of physicians, is reasonable and realistic. It accords the medical profession adequate safeguards against the imposition of wrongful suits. Maryland's legislature has acted to protect the physician in emergency situations by the passage of the so-called "Good Samaritan Bill". This bill excuses a physician from any negligence, other than gross negligence, when he treats a patient in an emergency situation. (Gross negligence has been defined by the court as a lack of care so marked as to indicate a wanton and willful neglect of duty.) This should obviate any fear on the part of the medical practitioner in rendering aid in accident cases on the highway. The likelihood of any successful litigation arising from your actions in aiding injured persons of automobile accidents are nil under the Good Samaritan statute.

The suggestion, made by the famous Melvin Belli, that "the real villain of the peace is not the law, anymore than it is the individual doctors, the real conspirators are the insurance companies. Insurance companies wield the whip that keeps medical men silent and in line." This is something I do not believe. I think that the current increase in actions against physicians is hardly indicative of a successful conspiracy in preventing the filing of suits.

I am persuaded that the doctrine of informed consent poses no problem to the Maryland physician. I don't believe that the cases that can be cited (in a number of states) that carry this thing to ridiculous lengths is going to meet with any success in Maryland.

It is encouraging to hear of panels of physicians who review cases of malpractice and follow a course that may lead to their conclusion either by recommending settlement or by urging defense. This is to be expected in Maryland, where, for many years, we have had an active relationship and exchange of views between physicians and lawyers. Even if we do not agree in our philosophies, and certainly in many instances we do not, we at least have an understanding of the position that the other takes, and can act realistically in considering that understanding.

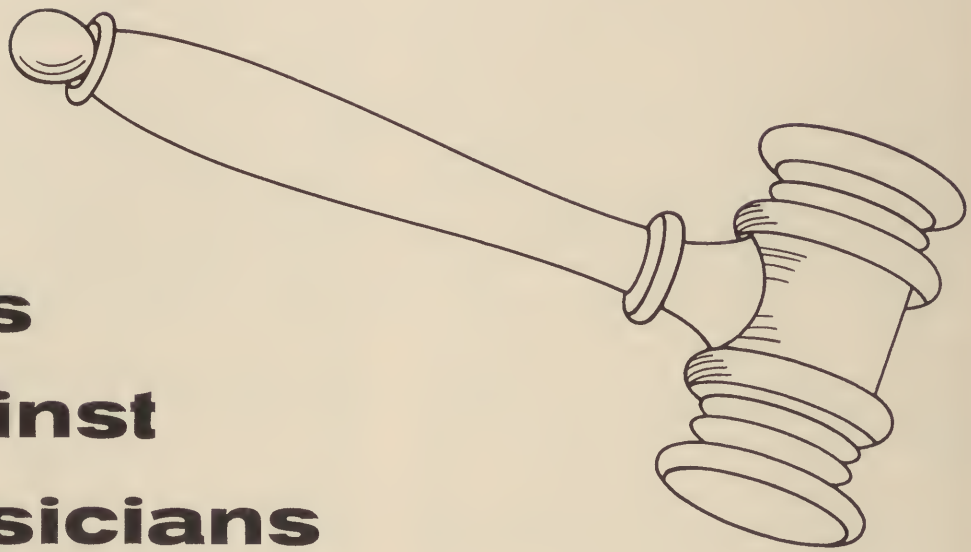
In cases concerning the extension of liability of a physician, the Maryland Court of Appeals, in a proper case, would uphold the liability against the physician on the vicarious liability theory. This would be the case in an operating room situation where the negligence charged against the surgeon would be an act of a nurse, or other assistant concerned with the operation. Surgeons should consider the fair possibility of liability being visited upon them under the theory of *respondeat superior* for the negligence of the nurse or assistant, even though their act, or failure to act was not known to the surgeon in charge in the course of the operative procedures.

A recent, and most interesting case was an effort to assert liability against a physician on the grounds of implied warranty. This was rejected by the Court of Appeals on the theory that, generally, actions against physicians are consensual in nature and that they do not involve implied warranty. Therefore, negligence must be shown. And the negligence that is required is the lack of standard and customary procedures used by other physicians in the State of Maryland under the same circumstances. This is a fair test by which the actions of a physician should be judged. The courts of Maryland are very careful to require a showing of negligence and that this negligence was the direct cause of the disability from which the individual suffers. It has been repeatedly held that *res ipsa loquitor* will not apply. That is, the mere showing of the existence of harm will not give rise to a presumption of negligence on the part of the physician, but negligence must be proven.

It is important to justice that the medical profession take a stand, in proper cases, for the rights of an injured plaintiff who has suffered as the result of negligence of a physician. Expert testimony is required in a vast number of malpractice cases and such testimony is a means to an end in the search for justice. When an expert is persuaded that harm has been done to an individual by the negligence of the physician he should testify in court. And there should not be any organized restraint placed upon the *offer* of such testimony.



It is the suit that is irreparably damaging to the physician and to this, that is the mere filing, there is absolutely no defense. This defenselessness to injury is one which physicians do not believe the Bar by-and-large fully appreciates and I will, therefore, set forth certain aspects of the effect of suit with the hope that with an awareness of these results, members of the legal profession will exercise exquisite professionalism before filing a suit against a physician.



Suits Against Physicians for Professional Negligence From the Defendant's Point of View

JOHN F. KING, ESQUIRE
Counsel for the Faculty

Professional Attitude Sullied

The first effect is not unmixed with others which are later considered, but it deserves individual and special mention. The physician who has been sued once has an outlook to everyday professional services rendered to any patient which can no longer be maintained solely with a pride in the nature and quality of his treatment and care. After a suit has been filed, the physician's professional view becomes colored, tarnished with the outlook: "do this according to the book—or else . . ." I have heard physicians say that after suit was filed, their entire professional atti-

tude has changed. The Tender Loving Care (TLC) elements, so essential to the realization of the nonmaterial rewards in the profession, suddenly seem out of place. The medical profession does not, for instance, condone the physician who shies away from an emergency case, but the reason why he does shy away is often found in a previously filed, unwarranted lawsuit.

Physician-Patient Relationship Strained

The second effect is like the first and no less important. The physician, once sued, may thereafter view each patient as a potential enemy, so that every step in the treatment is fraught with the decision: "Is this in the best interest of the patient, or must I do, or not do this for fear of being sued?". This decision-making is necessary, because unfortunately, the issues presented by the question are not always compatible with the same answer of good medical care. For example informed consent, a burgeoning principle under which suits are presently being filed against physicians, may now press a physician to disclose a malignant condition to a patient when such disclosure may not be in the best interest of the total welfare of that patient.

Recently, in the Maryland Legislature, a physician was asked, "Even where the drug Chloramphenicol is the only drug to combat what would otherwise be a fatal infection, ought not the doctor tell the patient that in one out of a million cases the patient may develop aplastic anemia?" In other words, scare the patient to death, rather than exercise a professional, responsible judgment.

The Standard Of Medicine Is Not Enhanced Or Elevated

Many attorneys, and lay people as well, claim that if the threat of suit were not present, the patient would not be as well cared for. This frightful contention is based on the premise that good medical care is rendered by the physician only to protect himself. The point of view is totally devoid of any recognition that physicians are healers called to pursue the art out of a desire to cure and comfort the sick. The threat of suit deters them in this endeavor—it does not assist them. Many procedures now perfectly acceptable in the care and cure of the sick would never have been explored had the physician been deterred by the fear of suit upon failure. Many past bad results would never have contributed to the total experience of medicine so as to guide the physician to future good results had he been controlled by the premise that threat of suit contributes to good medicine. Fear dictates *status quo* (conservative treatment) and this may not be the vigorous, scientific approach necessary for the solution of a vexing medical problem.

The Cost Of Medical Care Is Aggravated

This economic effect of suits being filed is a companion to the strained physician-patient relationship. If the patient is viewed as a potential plaintiff, then expenses must be incurred to prevent that relationship from developing. Lawyers need only represent a defendant in a criminal case by court appointment to experience this same kind of feeling. Interviews at the jail are now expensively recorded by some attorneys to protect them from "their client." Time of trial is protracted by extending every conceivable (whether tactically wise or not) safeguard to the accused—motions for new trial argued, appeals noted, etc., etc. An important distinction here is that in the client-lawyer relationship the taxpayers foot the legal bill, while in most physician-patient relationships, it is the patient's cost that is affected. This last effect is mentioned not to argue that physicians ought never to be sued, but that suits against physicians should not be so lightly undertaken as they are. Many suits filed against a physician are instituted without first getting an opinion from another physician that there had been a departure from accepted medical practice in the treatment of the plaintiff. To this the attorney may reply that he was driven to such ends because of the conspiracy of silence which physicians practice with respect to this problem. This contention brings me to the next effect of filing suit.

Physicians' Isolationism

The buckshot, trigger-happy approach of the lawyer in filing suits against physicians and hospitals has had the effect of driving the medical community into a tighter, less communicative, and perhaps overly defensive group.

That a group of people under attack, in this instance the medical profession, should withdraw unto themselves is a usual, predictable phenomenon. There is nothing conspiratorial or mysterious about such an event. Lawyers ask why physicians do not set up some system whereby the medical and legal professions can confer about bad medical results. The physicians' shrinking response to this is "First, put down your gun. We'll be glad to talk, if you'll not sue." The lawyer replies, "conspiracy of silence" and files suit. This stand-off can be avoided only by conscientious disciplining within both professions.

The medical profession should appreciate the necessity of suit being filed in the meritorious case. The legal profession on the other hand, should advocate restraint to the aggrieved patient where no negligence is present or no proximate cause operative to the patient's injury.

Lawyers settling a suit against a physician or hospital should sacrifice the likelihood of publicity with

respect to settlement in recognition of the injury such publicity does the physician. Unfortunately, I have seen lawyers refuse to have cases quietly marked "dismissed" and insist upon an open court settlement with all the attendant damaging publicity to the physician.

In an ordinary civil damage suit, a reasonable offer in settlement will be accepted without thought of refusal. There is no desire by the attorney or plaintiff to hold an insignificant defendant up to public ridicule. A similar offer for the identical injury if made in a "malpractice suit" will draw an immediate refusal—not because it is not compensatory to the patient but because the physician, his insurer, and ultimately the patient (in cost of medical care) will pay more for "his peace." This observation coming from a defense counsel will perhaps draw the observation—"sour grapes." While I have missed many a good settlement, I say no—this is not sour grapes, but a call to the Bar for professional restraint in exchange for which, in my judgment, the medical profession will develop an awareness from actual experience that suits against them are not being frivolously undertaken or ulteriorly pursued, and thereupon demonstrate professional responsibility on a level equal to the Bar's.

This has been demonstrated in actual practice where a case was settled for a reasonable sum when the defendant physician could not get one member of his profession to testify in his defense and plaintiff had five physician witnesses. Responsible plaintiff's counsel will acknowledge that in the example alluded to, the settlement was "compensatory"—not tinged with blackmail. From my experience there is no conspiracy of silence in meritorious cases, but the medical profession is understandably withdrawn when it is exposed to case after case which has no merit or where reasonable settlements are rendered impossible because the Bar considers the physician a "target" defendant.

Historian Arnold Toynbee in recently reflecting upon his age of 80, made this observation about technology: "Man has now decisively overcome nature by his technology, but the victor has been technology, not man himself. Man has merely exchanged one master for another and his new master is more overbearing than his former—nature used to chastise man with whips, man's own technology is now chastising man with scorpions."

And so it is that in an age when the medical profession should be held in highest esteem it is viewed with low regard. Medical science has made cure so available that the physician is cursed (sued) because he seemingly scurries from one patient to another which indeed he must do in order to make the achievements of his art available. Were he to take his time for tender loving care the cure for others would not be there. To the lawyer, the physician might be heard to say "be patient."

The Cure

In the face of the foregoing whips and lashes which the medical profession suffers as a result of litigation, the physician can reasonably ask: What is the medical profession doing about it?

The Medical and Chirurgical Faculty of the State of Maryland and its component societies make available to the members a consideration of the charges made against a physician-defendant in a malpractice case by convening a panel of the physician's peers. When a physician has been sued for malpractice he may request the Medical and Chirurgical Faculty to set up such a panel to consider the validity of the charges made, and pursuant to this request counsel for the Med-Chi convenes the panel which then considers the case under the following general format:

First, the charges made against a physician (as formally set forth in the legal pleading or declaration) are read to the panel. This should be of interest to the members of the Bar, because it is in the Declaration itself where presumably the patient, through his attorney, unencumbered by other considerations, is permitted and encouraged under the fact pleading of the Rules to set forth his case in its best possible light. It is thought, therefore, that the reading of pertinent parts of the Declaration will present the case in a posture most favorable to the patient.

Second, any definitive responsive pleading of the defendant physician is read to the panel. Examples of such pleadings are those which may be pertinent to a charge that the physician failed to procure proper consent, or a plea that limitations have run from the date the alleged wrongs should have been discovered.

Third, all documentation of the medical case is made available to the panel. This usually includes a hospital record as well as written reports from other physicians who may have considered an aspect of the case. The hospital records are not read *in toto*. Pertinent sections are read to the panel and the record itself is made available to each member for his individual consideration. The written reports of physicians (particularly those forwarded to counsel in the case) are usually read *in toto*, because it is in these reports that the respective positions of the parties in the medical sense are more clearly articulated and the issues more precisely delineated. Depositions, or more often resumés are read to the panel where they may touch on the medical aspects of the case.

Fourth, the defendant physician is asked to divulge all of the information which he has pertaining

to the matter and to state, in his own way, the defense, if any, which he may have to the charges made.

Finally, upon an indication from the panel that it is satisfied that the factual questions have been answered and that an adequate factual basis for its conclusion has been established, the defendant physician is excused to await the panel's deliberation of the case.

In the defendant physician's absence, the question put to each member of the panel is: "Should this case be settled or defended?" This question is followed by a definition, where necessary, of the legal considerations present with regard to the particular case, such as the meaning of the term negligence, erroneously styled "malpractice." The principles of negligence are explained so that the panel understands that it is not essential to a plaintiff's case that he show a malicious or intentional or wanton disregard of the patient but only that there was a violation of the standards of care usually and customarily adhered to in the practice of medicine by similar practitioners in this community. The panel is admonished that the standard of care in "this community" is usually as high as anywhere in the country since we are in a very sophisticated and accomplished medical community.

The panel and its individual members usually have questions of a legal nature which counsel endeavors to answer. When each member of the panel indicates his readiness, counsel asks for a vote, individually and by open declaration, as to whether the case should be defended or settled. This procedure usually stirs conversation and a re-evaluation of issues because as each member votes he explains his reasons and the exchange of views which ensues has been known to switch the position of the panel. A conclusion that the case should be settled is obviously predicated on the finding by the panel that the physician has been guilty of negligence in the treatment of the patient. The recommendation by the panel that a case should be settled is in furtherance of the Med-Chi policy that the best interests of the particular physician and the medical profession in general are not served by public trial of the issues presented.

On the other hand, a conclusion that the case should be defended furthers the policy of the Medical and Chirurgical Faculty that the best interests of the physician and the profession generally are served by vigorously defending cases where no negligence has been demonstrated and that it is detrimental to the best interests of the profession and the individual physician to countenance even a nuisance value settlement. In such a case the medical profession, to its credit, is fearless in submitting to an open public trial issues presented by the case, and the individual panel members themselves, thereby commit themselves to appear and testify on behalf of the defendant physician in the event the case comes to trial.

The effect of this means of evaluating individual litigation can be seen in the statistics. Only one case has ostensibly gone to trial when the panel concluded that it should be settled (ostensibly because the physician had negotiated a joint tort feasor release with the patient—settled as the panel suggested). Its being litigated was caused only because the co-defendant, in this instance a hospital, did not settle its liability for which it was held to be responsible. The good faith of the program, in terms of disposition of cases, is demonstrated by the fact that not one case has been left unsettled where the panel recommended its settlement; and in cases where the panel concluded that defense should be asserted, such defense has in all cases been asserted and, to date, with satisfactory results.

The foregoing program of the Medical and Chirurgical Faculty carried out under its By-Laws, has been held by a lower court opinion and recognized generally by the Bar to be a confidential procedure. Because of their training and their interest in the adversary proceeding, plaintiff's lawyers understandably object generally to any confidential procedure and it is frequently proposed that the Faculty make available to plaintiff's attorneys such an impartial panel. The *quid pro quo* offered by the plaintiff's attorney for such a panel is usually that should the panel conclude that the case was not meritorious he would dismiss the case or not file it in the first place.

This offer by the plaintiff's bar is hollow. It does not, as it must, recognize the rights of the patient-plaintiff to have his grievance aired in a civil proceeding as preserved to him under the Constitution, counsel's offer to dismiss or not file the case notwithstanding.

In conclusion—the injuries which the physician suffers as a result of the unwarranted, unmeritorious suit is the price which, in my judgment, the medical profession and the individual physician, must unfortunately be prepared to pay to the patient for making the right to bring such charge an unfettered one. It's the price of freedom and as long as our jurisprudence is predicated on the principles of adversary proceedings, and a person has the Constitutional right of jury trial, such injuries to physicians will continue. The salvation of the medical profession from these isolated instances of injury can only be realized through the steady disciplining of the legal profession, so that aggrieved patients who suffer from a bad result will not *ipso facto* assert that the physician was negligent. The answer is not, in my judgment, in the creation of an impartial panel system, but is only in the mutual professional disciplining and respect which we can all hope lies in the future.

The Need for Medico-Legal Cooperation in Treating Malpractice Suits

JOSEPH I. PINES, ESQUIRE
Baltimore

The problems of medical malpractice are deep-rooted. Physicians have nightmares about somebody called Belli out in California and they claim that the end result is that their insurance rates are skyrocketing and they are inhibited in their attempts to practice good medicine. Physicians are of the impression that patients and lawyers do not understand that a bad result does not automatically mean that a malpractice suit is in order. Lawyers are similarly unhappy because they claim that they cannot get the cooperation and assistance from the medical profession which they need to properly represent their clients, or the physicians are overprotective in their attitudes toward erring members of their own profession who do not deserve such protection.

In attempts to resolve these problems, our two professions have indulged in a merry-go-round of words and a ferris wheel of ideas, traveling horizontally, centrifugally and vertically, but never reaching any destination much beyond the original point of departure.

For a long time, the improvement of relations and understanding between physicians and lawyers has been a goal of mine, although an elusive one.

The nature of my practice has placed me in constant contact with members of the medical profession. I wish to assure you that I have a deep and abiding

respect for physicians, although I find it necessary at times to oppose them in the legal arena, or on relatively rare occasions become involved in malpractice actions against them. I am not unmindful of the fact that a physician brought me into this world, and in all probability that a physician will usher me out of this world. Neither am I forgetful that many members of my family and almost all of my dear and close personal friends are members of the medical profession.

Physicians are most crucial, if unwilling, participants in general litigation today. More than half of the practice of the average lawyer is devoted to personal injury cases, which are to the greatest extent determined by a medical issue.

Further, in the general opinion of the legal profession, it may well be encumbent upon the physician, in discharging his duty to the patient and his obligation to assist in the administration of justice, to attend the patient until such time as the patient is restored, as nearly as possible, to his former physical and mental condition and his former position in the community. The performance of this duty may entail a court appearance by the physician on behalf of the patient, despite the physician's fear of, and prejudice against, personal injury litigation (a prejudice probably born and nurtured in the midst of extensive propaganda to which the public has been exposed in recent years). The performance of this professional duty, to appear in court, has been largely relegated to those physicians who feel capable of weathering the legal storm.

At this juncture, it is of paramount importance to understand the basic difference in the philosophy of our two professions.

We lawyers live in a daily adversary proceeding. We expect our views, our opinions, and our judgment to be challenged. To the contrary, the medical profession, when it ventures off its medical reservation into the legal field, finds it difficult to adapt to the strange rules of the adversary proceeding. In your mind's eye, you tend to look upon the introduction of a viewpoint contrary to your own as an attack upon your personal ethics, integrity, training and professional respectability. Thus, when you become embroiled in this adversary procedure you enter timidly or are reluctantly pulled into the legal arena, where you view everything and everyone with a jaundiced eye and a skeptical and cynical fear of the unknown path ahead.

In general, physicians are critical of any member of the legal profession who has the temerity to institute a suit against a physician. It should be made eminently clear to you that there is a strong obligation and duty placed on the lawyer who represents an injured patient in a lawsuit against the errant physician. The lawyer has the right and the duty to present his cause in the light most favorable to his client by every lawful and ethical means at his command.

It should likewise be made clear that because of the gravity of the charge, there is an equally strong and corresponding obligation on the part of the lawyer to thoroughly and meticulously investigate and convince himself of the merits of the case before instituting the malpractice action.

It is standard procedure in our office to thoroughly and meticulously review a medical malpractice claim. It may surprise you to know that the number of cases accepted for handling is approximately one out of 25 or 30! If we determine that a case is not acceptable for handling, we take the time to explain to the client or his referring lawyer the reasoning by which we concluded that the case is not one to be pursued. I suggest that in many instances if the physician had taken a similar amount of time to explain to his patient, the patient more than likely would not have found his way into a lawyer's office.

We are all aware that the mere threat of suit against a physician is quite disturbing. We also know that the young or inexperienced lawyer often undertakes the handling of a doubtful malpractice case with the thought in mind that it will ultimately be settled before suit or trial. This is an unfortunate situation, one that should not be tolerated by either of our professions.

Unfortunately, we in the legal profession only have law schools and not lawyer schools. You only become a lawyer with experience, and many malpractice cases gravitate into inexperienced hands. No lawyer worth his salt should undertake a case knowing it to be tenuous. A malpractice claim is comparable to being pregnant—you either are or you aren't. I urge you and your legal representatives not to pay one cent for tribute nor one sou for nuisance value in the groundless malpractice case.

In many instances, the amount sued for is more than the amount of malpractice insurance coverage that the doctor has, causing him additional concern. Further, physicians maintain that because of the notoriety, it is humiliating to be sued in a medical malpractice case. That undoubtedly is true to an extent, but with increased specialization and the advent of, and emphasis upon community medicine, the physician-patient relationship grows less personal each year. With these developments, the stigma of the malpractice suit is also becoming less personal. In any event, the medical profession must not expect to be insulated from a lawsuit simply because of hurt feelings or because it is offensive to be sued.

We have geared our thinking to accept the fact that when we build a bay bridge, men will be killed or maimed during its construction. This does not deter us from building the bridge. Furthermore, Detroit knows that 50,000 people will be killed on the highways and many more injured each year. However, that doesn't stop production. We proceed because, in our collective opinion, the social utility outweighs the

harmful results. In the same vein, you should be geared to readily accept the practice of medicine with the frank knowledge that there may be an unexpected result for which you may have to shoulder legal responsibility.

I have attended meetings in this hall when attorneys representing liability insurance carriers have cited the statistics of malpractice cases in the Maryland Court of Appeals. Few, if any cases, have actually been decided in favor of a patient and against a physician. If you examine these cases carefully, you'll find that the medical profession has achieved hollow victories. In these reported cases, no one has declared that malpractice did not occur. The court merely reasons that the patient cannot meet the standards of proof—archaic standards that have been tailored for the medical profession.

Legal historians of tort law agree that the first half of the 20th century belongs to the defense. The second half belongs to the victims of the wrongs. Today, the walls of immunity are crumbling all around you. The medical profession's exposure to liability is expanding in many areas.

Since the courts can no longer count on the medical profession to help solve intra-professional or internal problems, the emerging trend in law finds the courts solving these problems independently.

The often-used phrase "conspiracy of silence" is slowly but surely being battered into submission. Physicians, unlike most other groups, have previously been allowed to set their own legal standards of conduct, merely by adopting their own practices. However, this has been altered in legal decisions of recent years. The medical profession is in a unique position —a physican can enter the halls of justice and tell us what is proper or improper, what is right or wrong in his profession. However, many have refused to do so. Many have abdicated their responsibility and entered into the "conspiracy of silence." The conspiracy of silence is not a mirage, but a fact of life well documented in legal opinions, texts, and studies. In the face of the abdication of such responsibility, courts are saying that 12 citizens (a jury) can determine the standards of the medical profession. Standards are being imposed on you—for you!—merely because you failed to respond to the invitation to face up to your responsibility. Juries see right through this abdication, and they react. Where convinced, they assess substantial damages against the defendant physician.

Often in malpractice trials, one of the best witnesses for the plaintiff, brought into the case by the defense, is the physician who feels that he has to protect the errant physician at all costs, no matter how ridiculous and untenable his position might be. This gives the jury an issue—a reason to become incensed.

Courts realize that the victims of medical negligence are in a predicament due to the ostrich-like behavior of members of the medical profession. They are aware that the so-called ethical practitioner will not testify on behalf of a plaintiff, regardless of the merit of his case. This is mainly due to the pressure exerted by either medical societies, or public liability insurance companies that issue policies and liability insurance to physicians covering malpractice claims. Courts know that physicians flock to defend their fellow members charged with malpractice, and the patient must depend on expert testimony from the heroic soul who, for the sake of truth and justice, has the courage to run the risk of ostracism by his fellow practitioners and the cancellation of his public liability insurance policy.

Judicial notice is being taken of the medical profession's continued reluctance to enter the legal arena and set its own standards. Therefore, the courts are devising measures to equalize the conflict (the even-handed policy).

Witness the development of the *Doctrine of Common Knowledge* in Professional Liability suits. This Doctrine is similar to, but distinct from, the Doctrine of Res Ipsa Loquitur. Under the Doctrine of Common Knowledge, the act or omission causing the injury must be proved but no expert testimony is required to establish the precise standard of medical care. The assumption is that a jury can determine the standard of care to be applied from its fund of common knowledge.

In an opinion handed down recently by the Fourth Circuit (of which Maryland is a part), an action was brought against a physician to recover damages for medical malpractice. The patient underwent an operation to correct a left ectopic tubal pregnancy. Inadvertently, the right ureter was sutured in two places, eventually requiring the removal of a kidney. It was conceded that there was no negligence involved. Because of the inherent risk of damage to the ureters in a case such as this, the physician contended that the suturing of the ureter was not the result of negligence on his part. If the plaintiff could recover damages, it must be on the grounds that the physicians were negligent in delaying their use of standard diagnostic procedures and that the delay necessitated the removal of the kidney. The court in this case ruled: "When it is known from expert testimony that a blocked ureter required immediate repair and that a standard diagnostic procedure (IVP) is indicated, *it does not* take a doctor *to decide how much delay is a failure to exercise due care.*"

The courts are supplying the missing link. Laymen are setting the standards for you—the medical profession.

Professional negligence against a physician may also be proven by his own statements both in and out of court. A recent Maryland case involved three means of proving malpractice where experts were not available:

1. It was held proper to call the defendant doctor as an adverse witness and elicit from him an opinion regarding the standard of practice.

2. Hospital records endorsed by the physician were entered into evidence as an adoptive admission.

3. Conversations between the physician and the patient were held admissible as a basis for negligence or malpractice.

Currently the citadel of the *Locality Rule* is being besieged. Under the strict and narrow version of this rule, the competence of an expert medical witness to testify about the standard of care is determined by his familiarity with care ordinarily exercised in the same locality in which the defendant practiced. If the courts had continued to strictly apply the Locality Rule, malpractitioners would erect a fortress of immunity as a ready refuge for medical negligence. Forces are at work leading to a liberalization of the rigorous Locality Rule. The liberalization of the Locality Rule has been generated by transformation in American life, medicine, and judicial attitudes. Improved means of transportation and communication, the availability of continuing medical education, and the increased excellence of medical schools has led to a judicial re-evaluation of the Locality Rule. All of this has combined to create one community of medical practitioners out of the 50 states and the District of Columbia. Thus, a doctor from any part of the country may soon be competent to testify anywhere in a malpractice suit involving a "settled" practice.

Another avenue of liability being opened to plaintiffs rests on the *Doctrine of Informed Consent*. There is sturdy support for this doctrine which imposes upon physicians the responsibility to warn their patients of risks of probable adverse results in proposed diagnosis or treatment. It is being strongly urged that a physician's duty to warn a patient should not be measured by the general practice followed by the members of the local medical profession. The determination as to whether this basic duty has been violated is being wrested from the indulgent and not altogether disinterested keeping of the defendant-physician's colleagues and is being placed on the jury.

So, we are beginning to see vexing medico-legal questions being approached and resolved by the seasoned reason of the common law. In the past decade, there has been a veritable cloudburst of cases throughout the country which inspire trust in the competence of the civil jury to bring to medico-legal questions a tested common sense, a common sense which is neither manacled in dogma, frozen in a formula, or subservient to a particular partisan medical view.

In time, the medical profession will mature to a point where it will not view malpractice cases quite so personally, as it does today. It will come to realize that each physician is a human being, and, being human, is capable of error and, that if error is committed to injure an innocent party, then that injured party should receive monetary damages. The image of a malpractice case by a lawyer or a disgruntled patient as a "figment of the imagination" must be erased by the medical profession.

Hopefully, you will come to the realization that there is not always a community of interest between the medical profession and the liability insurance companies and their representatives. Hopefully, you will separate fact from fiction in the mounds of malpractice propaganda that has been targeted toward you, and you will resist the external economic, social, and professional pressures.

The truth always originates in a minority of one, so the prescription to solve the malpractice problem lies within each individual's capability of breaking the existing precedents. Up to now, the collective keeper of the physician's conscience has not been the medical profession, or the individual physician, but the liability insurance industry. I submit that over the years, they have charted a course for you which has proven to be self-defeating. Very simply, I suggest that you reclaim your collective conscience. This may smack of heresy, but the heresy of today is the commonplace of tomorrow. Let's work toward one goal—the fair and honest administration of justice.



your medical faculty at work

by John Sargeant
Executive Secretary

The Council met on November 20, 1969, and took the following actions:

1. Endorsed the proposed Bylaw amendments to be submitted to the Special House of Delegates session on Saturday, December 13, 1969, at 2:00 PM;
2. Agreed to recommend Emeritus Membership to the House of Delegates for certain members, all at the request of the component society involved;
3. Adopted Council meeting dates for 1970;
4. Changed the Faculty's personnel policies to provide that professional librarians will receive four weeks vacation each year; with the understanding that it will be pro-rated during the first year of employment and will not change with increases in tenure of employment;
5. Heard a report from Raymond T. Holden, MD, of Washington, D.C., a member of the AMA Board of Trustees, who discussed various activities of the AMA;
6. Authorized appointment of the firm of Anderson, Coe and King as legal counsel for 1970;
7. Adopted a Revised Laboratory Services Policies, as recommended by the Executive Committee. (See next page for the revised policy);
8. Authorized the President to name an Ad Hoc Committee on New Faculty Building. This group is to investigate, in detail, all the various facets of such a move, such as space requirements, building requirements, costs, etc, and to make a report to the Council or House of Delegates;
9. Adopted the Financial Operating Statement and Dedicated Fund Statement through September 30, 1969;
10. Authorized the President to make recommendations for appointments to the various steering committees of the Advisory Council on Comprehensive Health Planning for the Baltimore Metropolitan Regional Planning Council;
11. Agreed to notify component medical societies and the various state-wide Specialty groups of proposed changes in the Tax Reform Laws of 1969 currently under discussion in the U.S. Senate Finance Committee;
12. Voted to disapprove a recommendation of the Professional Medical Services Committee that would have permitted this committee to collect valid data concerning charges for physicians' services.



Revised Policy of the Medical and Chirurgical Faculty of the State of Maryland in Connection with Laboratory Services and Billing

In June, 1965, the Council adopted certain ethical standards for physicians to follow in connection with laboratory services for their patients. Since that time, the State has adopted a licensure law for the operation of laboratories and, in addition, has established regulations (which have the force of law) within which laboratories must operate.

It is obvious, therefore, that Faculty policy should be re-examined in the light of the current situation and the policy in effect be revised if it is considered desirable to do so.

The Executive Committee, therefore, recommends that the following be adopted as Faculty policy in connection with the use by physicians of laboratories in Maryland, as well as in the use of laboratories which operate on a "mail-order" basis and to which physicians mail specimens.

Revised Policy

Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory because it provides him with low cost laboratory service on which he charges the patient a profit is derelict in not acting in the best interests of his patients. However, if reliable quality laboratory services are available at lower cost, the *patient* should have the benefit of such savings.

It is imperative that the physician be assured that his patients are receiving the highest quality of laboratory services. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless he has the utmost confidence in the quality of its services. One manner in which this confidence could be put to a test is whether he would use these same services for himself or any member of his family.

It is preferable that the laboratory, not the attending physician, bill and collect from the patient or third party payor for laboratory services. Where circumstances make this impractical or where increased costs to the patient would result, the bill submitted by the attending physician to his patient or third party payor should provide information to show where such services were performed, as well as an adequate description of the services provided and the specific charges made by the laboratory for the tests, as well as his procurement and processing charge.

The Attending Physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission or profit on the services rendered by a laboratory is exploitation of the patient.

A contractual agreement between a laboratory and a physician is generally not in the best interests of the patient and could be construed as "exploitation of the patient." If a physician enters into such a contractual arrangement, it is impossible for him to ascertain his cost per test performed and so bill in accordance with the preceding statement. If such a contract is entered into by the physician, the only manner in which "exploitation of the patient" *could not be construed* is if the physician absorbs this monthly contract charge into his regular office overhead. In such a case, no individual billing for individual laboratory test performance would take place. A true cost cannot be determined for specific tests under such a contract that allows a sliding scale of fees depending on the volume of tests performed.

Regulations issued by the Maryland State Department of Health require that all laboratories offering services in Maryland be registered with that department, before the provision of such services. Physicians who utilize the services of non-registered laboratories may find themselves in violation of Maryland law.

It shall be considered unethical for a physician to:

(a) Submit specimens to any laboratories not professionally and adequately supervised in accordance with State laws and regulations.

(b) Bill in a manner not in accordance with previous statements of policy enumerated in this document.

(c) Send specimens to any laboratory rendering such services at a flat fee, unless the cost of such services is included as a cost of his normal office overhead.

(d) Share income from laboratory services either directly or indirectly with any lay person.

(e) Offer laboratory services under a fictitious name.

(f) Have a financial interest in any clinical laboratory where the physician is not personally and professionally responsible for the quality of the work performed in the laboratory.

(g) Collect fees from any third party payor or the patient for laboratory services not performed by him or his regularly employed assistants, without full disclosure as enumerated in the fourth paragraph of this revised policy.

Recognizing the need for the physician who operates a laboratory to acquaint physician-members of the community of the services available for patients, it is considered ethical for a physician to:

Send to any other physician of his choosing an announcement that he has opened an office, changed the location of an office or changed the professional composition of his office for the practice of medicine, in the format approved by the Medical and Chirurgical Faculty. Return forms that serve only to facilitate the communication between the interested physician and laboratory but do not in themselves give specific information, such as fees, office hours, special qualifications, other than membership in professional Boards or Societies, are acceptable. Fee schedules and other specific information material may be sent only to those physicians who request them or who regularly utilize the facilities of the laboratory.

It is considered unethical for:

(a) A lay employee, directly or indirectly, to solicit work from physicians.

(b) To advertise laboratory services in any media such as magazines, journals, newspapers, etc.

(c) To display any advertising material on vehicles.

(d) To distribute mailing containers except on request.

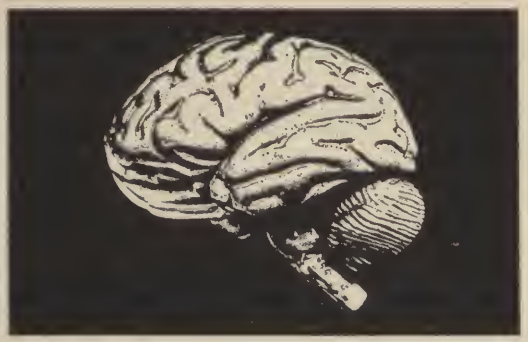
It is recognized that laboratories operated by non-physicians are not bound by these ethical guidelines. However, the practice of Pathology being considered an integral part of the practice of medicine, Pathologists cannot be considered differently than other physicians such as the general surgeon who is not permitted to send out brochures extolling his willingness and ability to perform surgical services for the physician's patient.

In adopting the above policy, the Medical and Chirurgical Faculty's Council urges that every effort be made to have included in the Laboratory Regulations issued by the State Health Department the same ethical guidelines to which physicians must adhere.

Suggested regulations could read as follows:

NO PERSON, PARTNERSHIP, ASSOCIATION OR CORPORATION SHALL WITHIN THIS STATE, EITHER DIRECTLY OR INDIRECTLY, ADVERTISE OR SOLICIT BUSINESS FOR ANY LABORATORY WHETHER SUCH LABORATORY IS SITUATED IN THIS STATE OR ANY OTHER STATE, OR PROVIDE REBATES OR OTHER FEE SPLITTING ARRANGEMENTS WITH RESPECT TO LABORATORY SERVICES. HOWEVER, A SIMPLE ANNOUNCEMENT OF AVAILABLE SERVICES MAY BE PROVIDED TO LICENSED PRACTITIONERS OF THE HEALING ARTS. THE CONTRACTUAL PROVISION OF LABORATORY SERVICES FOR A FIXED FEE INDEPENDENT OF THE NUMBER OF SPECIMENS SUBMITTED FOR SUCH SERVICES IS DECLARED TO BE A VIOLATION OF THIS SECTION.

Adopted by Executive Committee, 10/30/69
Referred to Council, November 20, 1969
Adopted by Council, November 20, 1969



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Voluntary Admissions

The number of patients who were self-admitted to Maryland's psychiatric hospitals increased from 1,748 in 1962 to a record 4,412 (or 36.8% of all admissions) during the 1968 fiscal year. The following table shows that much of this rise reflects the rapid growth in admissions for the treatment of alcoholism. As indicated, the number of these patients has more than tripled in the last six years and now accounts for 49.7% of all admissions, as compared with 28.7% in 1962. Alcoholics have a higher than average percentage of voluntary admissions. The increasing proportion of total admissions with this diagnosis has therefore produced a concomitant rise in the number and percentage of total voluntary admissions. Within most of the diagnostic categories shown, the proportion of self-admissions changed only slightly between 1962 and 1968.

Reported Primary Diagnosis	Number of Admissions		Percent Voluntary in Each Diagnostic Group	
	1968	1962	1968	1962
TOTAL ADMISSIONS	11,997	6,221	36.8	28.1
ALCOHOLISM	5,957	1,785	46.6	44.4
PSYCHONEUROTIC REACTIONS	757	424	50.6	52.8
OTHER PERSONALITY DISORDERS	737	410	29.3	34.4
SCHIZOPHRENIA	1,725	1,738	29.1	19.2
OTHER PSYCHOTIC DISORDERS	359	354	38.2	33.6
DISORDERS RELATED TO OLD AGE	647	730	7.3	5.9
MENTAL RETARDATION	129	157	20.9	10.2
ALL OTHERS	1,686	623	19.2	13.2

A number of other factors also related to the relative frequency of voluntary admissions. These included:

1. PREVIOUS HOSPITALIZATION STATUS—33.0% of admissions with no reported prior psychiatric hospitalization and 39.5% of readmissions were voluntary. Excluding alcoholics, these percentages were reduced to 24.0 and 30.3, respectively.
2. RACE AND SEX—The percentage of voluntary admissions varied from 40.6 for white males to 36.4 for white females, 30.8 for nonwhite males and 28.9 for nonwhite females. This sex difference was mainly related to a seven to one male-female ratio in admissions for alcoholism. The racial variations, however, reflected a continuing greater use of the voluntary admission procedure by white residents.
3. AGE—Voluntary admissions were relatively most frequent in the age group 25 to 44 (41.5%) followed by those between 45 and 64 years of age (38.5%). In the youngest age group, under 25, 30.8% of admissions were voluntary. Among those 65 years of age or older, where most admissions are for problems related to old age, only 7.0% were voluntary.

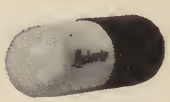
Many individuals requiring psychiatric hospitalization have sufficient recognition of their illness to accept treatment services voluntarily. Since this initiative is considered to be a potentially positive factor in the treatment outcome, major efforts to encourage use of this procedure are warranted.

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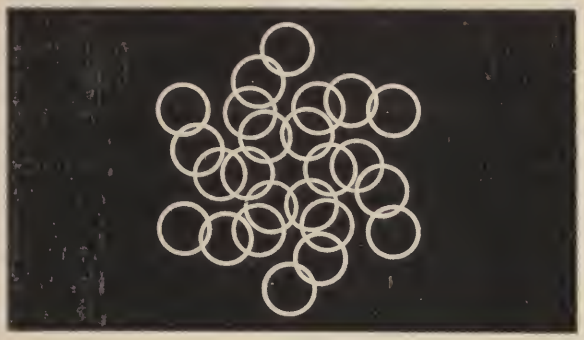


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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

One For The Plant

RALPH E. WINTER
Staff Reporter of *The Wall Street Journal*

Drunk Employees Rise but Labor-Short Firms Often Don't Fire Them
Concerns Try Rehabilitation, Score Startling Success; A $4 Billion-a-Year Problem
Costly Caper of Drunk Santa

COLUMBUS, Ohio—Something was wrong. The crane operator was operating his crane erratically, so his supervisor at Buckeye Steel Castings Co. signaled him down. "What's the trouble?" the supervisor wanted to know. And, he asked, why couldn't the crane operator walk a straight line—and why did he smell of alcohol so early in the morning?

"I had a beer before I came to work," the operator answered bellicosely.

Indeed he had. And he hadn't stopped with just one, an on-the-spot check with a breath analyzer disclosed. In fact, the test indicated the man was roaring drunk. And so the crane was idled and the people at Buckeye Steel Castings chalked up a few more hours lost to drink.

But the crane operator wasn't fired, as he almost surely would have been a few years back. Rather, under threat of firing he enrolled in the company's problem-drinker program. Thus, company officials hope to help the man salvage his life—and, somewhat less altruistically, to help themselves salvage a worker in these times of severe labor shortage.

Reprint Permission Granted by *The Wall Street Journal*, October, 1969.

The Corporate Conscience

A drunken worker, of course, is not a new problem. But it is an increasing one, and it is especially troubling employers now because many of them have developed corporate consciences and hate to fire a worker for what they now view as a disease—because if they did fire a worker it would be very difficult to find a replacement now that the unemployment rate is so low. One result is that there now are formal drinker-rehabilitation programs at an estimated 1,000 companies, ten times the number a decade ago.

The dimensions of on-the-job alcoholism are elusive because most drunks are able to conceal their problem. "It's an iceberg, with the biggest part hidden from management," says an official of Anchor Hocking Corp. of Lancaster, Ohio. Buckeye Steel, a Buckeye International Inc. subsidiary that discusses the problem more candidly than most companies, estimates that 18% of its employees have a drinking problem that affects the company. That rate is probably higher than average, because

Buckeye studies have found that the rate tends to run high in the foundry industry, where the labor pinch is particularly acute.

There's no question the problem is worsening. Officials at the National Council on Alcoholism estimate that alcoholism costs American employers $4 billion a year in lost time and ineffectiveness. That's up from an estimate of $1 billion five years ago, although officials now say that the 1964 estimate was too low.

"Alcoholism is more prevalent in industry than it was five years ago," agrees J. J. Davis, president of Esco Corp., a Portland, Ore. alloy steel foundry. "It may be the result of greater affluence in that people have more money to buy booze. And they know employers can't fire them so readily in a tight labor market."

A Jolly Santa's Caper

Whatever the reason a worker shows up drunk, it can foul up operations. Efficiency experts reckon that North American Rockwell Corp. lost 500 man-hours of production as employees gathered to gawk and talk one December day after a drunken worker donned a Santa Claus costume and romped for an hour through an aircraft plant.

Excessive drinking is the biggest single factor in absenteeism, itself industry's biggest personnel headache, according to L. R. Price, executive vice president of the American Society for Personnel Administration. Records at North American Rockwell's division here in Columbus indicate that employees with drinking problems average an extra 30 days of absence annually, most of which must be made up by other employees on overtime. Counting only the 310 hourly workers that have entered the company's problem drinking program, this figures out to added costs of $125,000 a year unless their drinking can be controlled.

What's more, when a drunken worker does show up he's often aware he isn't functioning properly and thus slows down to avoid accidents or mistakes. A heavy drinker may reduce his output by 50% or more, authorities say. Mistakes made by on-the-job drunks add thousands of dollars more to companies' costs.

Keeping an Eye Peeled

One result of all this costly boozing by all these scarce workers is that companies are making a bigger effort to spot the alcoholics early when there's considerably more opportunity for rehabilitation. "I tell supervisors to be alert for any change in behavior, such as the jovial employee who becomes morose or the gregarious guy who turns into a loner," says Dr. Luther A. Cloud, senior associate medical director for Equitable Life Assurance Society of the U.S. and president of the National Council on Alcoholism.

Other signs Dr. Cloud looks for: "Any irresponsible behavior or general loss of efficiency, chronic lateness, prolonged lunch hours and leaving early on Friday." He says that "the typical pattern of Monday absences and physical symptoms like tremors and sallow complexion come later—when we see a man at that stage, it's late."

Surprisingly, even though companies are on the watch for alcoholics, the average employed alcoholic isn't discovered until he has had a drinking problem for ten years, one study said.

Once discovered, the drunk is usually turned over to a company doctor and an "employee alcoholism counselor," which is a new speciality at many major companies. The hardest problem for these doctors and counselors is getting the employee to admit he's an alcoholic. "Sure I drink, but I can control it," the man often says. Or, "I don't have a drinking problem. My problem is paying the rent."

After that barrier is broken, most companies with formal rehabilitation programs follow a common pattern of treatment. They generally insist on a thorough physical examination, with hospitalization in alcoholic wards if the case is severe. Almost invariably, the employee is urged to join Alcoholics Anonymous for group therapy, with other AA members at the company taking him to the first few meetings. North American Rockwell sponsors AA meetings on company premises, and other companies, such as Equitable, give time off to attend meetings outside the office.

Corporate specialists also enlist the assistance of community resources, including church groups, public clinics, welfare agencies and social workers. The companies sometimes arrange loans to help solve financial crises, which all alcoholics seem to have. "I've never known an alcoholic who wasn't in debt," says one doctor who works with alcoholics, "and that includes two company presidents with incomes of over $100,000 a year."

"When a man has lost his house and his family, is living in his car in the parking lot and has had his paycheck garnisheed, he needs more than a lecture," says one employee alcoholism counselor.

Some companies also insist that a worker take medicine, frequently a drug called Antabuse that remains dormant in the body until the person drinks alcohol. Then he gets violently ill. "My ears burned, the veins on my hands stood out and my heart jumped out like this," recalls one reformed alcoholic, holding his hands six inches in front of his chest. "Then my legs got rubbery and I went down."

But making sure workers take the drug is difficult. Some companies insist the workers take the pill each day in the presence of a supervisor or company nurse. Even that isn't foolproof. Frank Marsh,

chairman of the United Auto Workers alcoholic committee at a Fisher Body plant here, says that some workers try to pass off other, similar pills as Antabuse.

But once a worker is on the way to kicking his habit, he is usually grateful for the help he has been given. Don Harris is the alcoholism counselor at Buckeye Steel Castings here, and he has a Spartan office by the plant gate where workers periodically stop in to see him. (Workers wouldn't come to a fancy office with a receptionist, he says.) He sees lots to encourage him.

On one recent day, a gold-shirted man in his 40s came in with a big smile and a firm handshake. He had just come out of 14 days in a hospital's alcoholic ward, the longest period in recent years that he had gone without a drink. He felt great, he said, and he was confident that, with the help of Alcoholics Anonymous, he could whip his problem. A father dropped by to say he had been sober for 30 days.

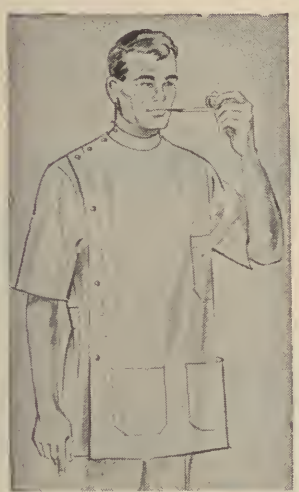
Indeed, big companies say they have a startling success rate of 55% to 70% in returning problem drinkers to sobriety. This is far higher than the recovery ratios at hospitals and treatment centers for alcoholics, but doctors say there is a reason.

Explains Dr. Gordon M. Hemmett of Eastman Kodak Co.: "Alcoholics need some sort of crisis to break through the wall of denial that they have a drinking problem. Threat of job loss is a very potent means of creating a crisis for the purpose of getting the alcoholic's attention." And once the worker recognizes his problem, doctors say, a company has effective leverage in that he either must cooperate in rehabilitation or be fired.

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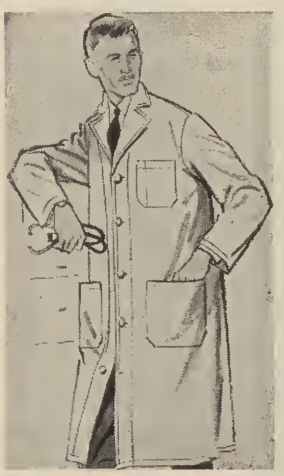
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The First Breath

Life hangs on the infant's first breath, yet all factors that operate to bring off the event safely are not clearly understood. One essential is that lung surfactant be present and at birth form a surface film in the alveoli to stabilize the peripheral air spaces.

One of the marvels of the birth of a child is the remarkable adaptation from intrauterine to extrauterine life. That the infant, when delivered, will give a lusty cry has come to be taken for granted. Failure of the event, or its delay, is tragic. Undoubtedly, adverse events at the time of delivery are the cause of significant neuromuscular and cerebral deficits in later life.

Thus, one approaches the problem of the initiation of breathing not only with the curiosity of the scientist and the attitude of pursuit of understanding for its own sake, but also with the realization that, with further understanding, morbidity and mortality associated with birth may be reduced.

Since the fundamental physiologic mechanisms of the initiation of breathing are essentially the same for all animals, there is abundant opportunity to study this phenomenon and to apply knowledge gained from animal studies to humans.

In a study with goats, it was found that the fetal lung weighed nearly twice as much as the postnatal aerated lung. The difference was due to the presence of liquid. Histologic examination showed that the liquid was mostly in the airways. This means that the fetal lung near term is distended with a volume of liquid about equal to that of the functional residual capacity after replacement of the liquid by air.

Air-Liquid Interface

With the introduction of air into the lung, there is an associated increase in pulmonary blood flow. Because the osmotic pressure of the blood exceeds that of the lung liquid, the osmotic forces favor the movement of liquid into the blood. The creation of an air-liquid interface produces local pressure differences within the lung that allow for drainage of the liquid from the terminal air spaces.

Delay in the process of clearing the lung of liquid sometimes leads to a clinical syndrome which may be called transient tachypnea of the newborn. The outstanding feature is a significantly elevated respiratory rate; rales are usually absent, which is consistent with liquid in the interstitial spaces. Heart sounds are normal, as are blood gases. The tachypnea may last for 24 to 72 hours.

As for the stimuli that must be operative in the initiation of breathing, various studies have shown that tactile, thermal, and sensory stimuli can increase the output of the respiratory neurons. Chemical stimuli, which are always in the direction of decreasing Po_2 and pH and increasing Pco_2 during the birth process, are able to stimulate the first breath and doubtless are critical to the maintenance of respiration. However, with a prolonged second stage of labor, the blood gases can quickly reach necrotizing levels. Thus, use of CO_2 as a respiratory stimulant or allowing for further hypoxia is not going to be constructive in assisting the first breath, and could be lethal.

Change in Temperature

In recent years there has been a great deal of interest in whether change in temperature is important in initiating breathing. In most parts of the world, the infant is exposed to a sudden change in temperature from 99°F of intrauterine life to about 70°F room temperature. Whether this is important or is only an associated event is not clear. Other possible influences on initiating the first breath have also been studied, but at present, priority cannot be assigned to any one.

The first breath also raises the question of the

Mary Ellen Avery, MD. The Amberson Lecture. *American Review of Respiratory Disease.* September, 1969, Vol. 100, No. 3.

first expiration. Obviously, if all the air that entered the lung were to leave it on expiration, every breath would resemble the first breath. It is necessary for the normal pulmonary adaptation at birth to create a functional residual capacity. This can be achieved only if the pulmonary surfactant is present and a surface film is formed at the moment of birth, allowing for the stabilization of the peripheral air spaces.

Studies at the time of appearance of the surfactant in fetal animals show that toward the end of gestation surfactant is always present, although at different times in different animals.

Chemical analyses of lipids have shown that the concentration of surfactant is higher in the newborn than in the adult. Since surfactant is so critically important to the retention of air in the lung at end expiration, perhaps there is an abundant supply available in the newborn to permit air retention in association with the first breath. Or, it could be that the mechanisms for the removal of surfactant are not operative in the fluid-filled lung and an accumulation occurs. In any event, it seems that the newborn is particularly blessed with an abundance of this essential surface tension-lowering substance.

When surfactant is deficient or further synthesis is impaired, the consequences are a tendency to airlessness with each expiration and, of necessity, the application of high applied pressures to maintain respiration. This leads to marked retractions commonly associated with atelectasis and hyaline membranes, a disorder characterized at death by a deficiency of the pulmonary surfactant. The half life of lipid components of surfactant have been estimated at approximately 14 hours. This raises the question of whether some infants who have minimal respiratory difficulty in the first hours of life may suffer from an impairment of further synthesis of this essential compound. Their worsening pulmonary status during the second and third day of life may then represent its utilization and failure of formation.

Learning from the Infant

Many of the details of how the infant can be assisted in taking his first breath are lacking, but it must be remembered that each breath after birth differs in some respects from the one before. As the lung liquid clears, the mechanical properties of the lungs change, blood gas tensions change and, therefore, any respirator must adapt to the events taking place in the infant or be operated by someone skilled in artificial respiration who can assist the infant.

Advances in physiology with respect to understanding respiratory control mechanisms and other events associated with respiration at all ages will, it is hoped, enlarge our understanding of the first breath. Possibly, too, further attention to this most significant event would throw light on respiratory problems at all ages.

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Baltimore City health department

Highlights

Rubella Campaign Begins

A total of 10,789 children in Baltimore public schools received the new rubella vaccine in the first phase of the local Rubella Immunization Program. Those children immunized attend 35 randomly selected schools and are enrolled in Early Admissions, kindergarten, first, second, and third grades.

Conducted on November 3, 4 and 5, 1969, the immunization program will be continued as additional funds and vaccine become available. While the first priority target in the city rubella campaign is 16,000 children in the five- to eight-year-old age group, a total of 3,739 parochial school children of similar age received German measles vaccine in a preliminary vaccine study conducted by the Division of Infectious Diseases of the University of Maryland School of Medicine in early 1969.

The Maryland Rubella Immunization Program is jointly sponsored by the Medical and Chirurgical Faculty of Maryland and local medical societies and health departments, local departments of education, and local voluntary health organizations. Chairman of the Baltimore City School Immunization Program is John B. Saratsiotis, MD, Director of the Bureau of School Hygiene in the Baltimore City Health Department. Other members are Robert E. Farber, MD, Commissioner of Health; John B. De Hoff, MD, Deputy Commissioner; James D. Carr, MD, Assistant Commissioner for Local Health Services; Miss Alice M. Sundberg, Director, Bureau of Public Health Nursing; Allan S. Moodie, MD, Director, Bureau of Communicable Diseases; Mr. Joseph Gordon, Director, Bureau of Health Information; and Mr. John H. Westerholm, Public Health Advisor of the U.S. Public Health Service assigned to the Baltimore City Immunization Program.

Air Pollution Control

A major advance in the Baltimore City Health Department's efforts to provide cleaner air for Baltimore took place recently when the Armco Steel Corporation dedicated a new dust control system. This is a million dollar project which had its beginnings in 1965 following discussions between Armco management and the Department's Bureau of Industrial Hygiene.

The new Armco air pollution control installation will improve the city's environment by filtering 230,000 cubic feet of air per minute containing iron oxide particles which previously had been emitted into the atmosphere.

Other noteworthy air pollution control activities under surveillance by the City Health Department in recent months include: the recent installation of a gas jet-engine electric generator at the Westport station of the Baltimore Gas and Electric Company to eliminate the emissions from three stacks connected to low pressure coal burning units, a source of air pollution in the area for many years; the installation of a baghouse collector device for smoke and particulate matter on a cupola of the American Brake Shoe Company; and the installation of dust collection equipment at the Peavey Grain Company to eliminate grain dust in the Locust Point area.

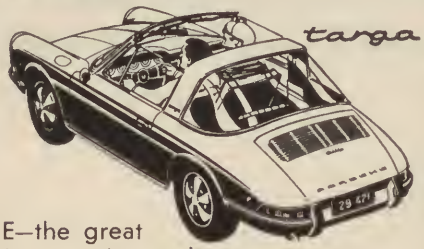
The above are a few of the more recent industrial improvements directed at curbing the city's air pollution. Overall, the City Health Department maintains constant surveillance of the atmosphere with four air monitoring stations located at strategic points in the city. It is also noteworthy that in 1968 some 504 building plans were examined for compliance with air pollution control requirements.

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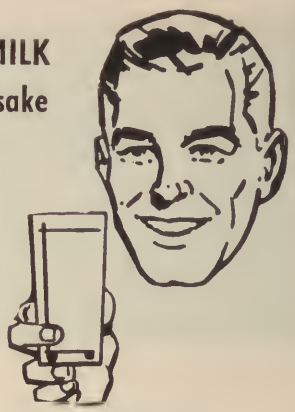


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MRS. FRANK A. FARAINO, EDITOR

woman's auxiliary

Auxiliary Members Attend Workshops

Six members of the Executive Board of the State Auxiliary attended the Eastern Regional Workshops on October 23-24, 1969, at the Sheraton Park Hotel in Washington, D. C. They were: Mrs. Wallace H. Sadowsky, president, who attended the sessions on Health Careers in the absence of Mrs. Robert J. Dawson, State Health Careers chairman; Mrs. Raymond M. Yow, president-elect; Mrs. Elmer G. Linhardt, state chairman for AMA Education and Research Foundation; Mrs. Harold P. Biehl, state chairman for Children and Youth; Mrs. S. G. Sullivan, treasurer, who attended sessions on Membership; and Mrs. DeWitt DeLawter, state chairman for Legislation.

Mrs. John Chenault, president of the Woman's Auxiliary to the American Medical Association, welcomed the representatives from the 13 states and the District of Columbia and expressed hope that the workshop meetings would help provide answers to problems that state chairmen might have, as well as stimulate enthusiasm. Raymond T. Holden, MD, a member of the AMA Board of Trustees, addressed the group and extended wishes for successful endeavors.

Mrs. G. Prentiss Lee, 1st vice president of the national auxiliary and Membership chairman, set forth the purpose and procedure of the meeting and introduced Mrs. Herbert J. Ulrich, regional vice president, who then introduced the national chairmen of the six committees involved in the workshop.

Mrs. Howard G. Ellis, national auxiliary chairman for the AMA Education and Research Foundation, stated that in the past 15 years $68,000,000 has been donated to the Foundation by physicians and their wives, and $43,000,000 had been contributed to the student loan program, enabling 39,000 students to complete their medical education. The auxiliary actively participates in raising funds for financial assistance to medical schools and the Loan Guaranty Fund. The auxiliary gave unrestricted funds to 113 medical schools in January and February 1969 and also to the Biomedical Research Institute, which was the only agency for primary research in the country supported completely by unrestricted funds. The Guaranty Loan Program was reactivated as an auxiliary project in 1969 because of the impact of increased tuition and related living costs, tight money, and a cutback in federal loans. Loan applications, pouring into AMA at an unprecedented rate, have depleted the reserve which had been built up from repayment of loans. In the month of September, 800 loans were made to medical students, and it is estimated that for the academic years 1969-1975, there will be a need for 203,000 new loans amounting to $26,310,000 to enable students to complete their medical education. The auxiliary contributed $428,875.77 in 1968-1969 and it is hoped that this proud record will be surpassed in 1969-1970.

Mrs. Paul E. Rauschenbach, national auxiliary chairman for Children and Youth, said that her committee is concentrating on building a strong family unit. Since 50% of a child's ability to learn occurs during the first four years of his life when his mother and father are the only influencing factors, the atmosphere of his home during this period is most important.

Mrs. Wendell Roller, national auxiliary Health Careers chairman, stated that health power is people power, and that people are needed to help create

strong health power. Three factors are involved: recruitment for health careers, training of skilled personnel to perform health services, and funding (loans and scholarships) to enable young people to enter the health field. Inactive and retired health workers must be encouraged to return to service. Refresher courses and the establishment of child day-care centers play an important role.

Mrs. William R. Flood, national auxiliary Legislation chairman, said that every auxiliary member must be informed, inform others, and become involved with all health-oriented legislation, plus community, state and national issues important to every citizen. She announced a new concept that has been added to the national legislative program, to be implemented on the local level. The auxiliary has been asked by the AMA to include involvement in public affairs in its legislative program. A kit has been prepared suggesting ways to encourage more participation in public affairs projects within the community.

Mrs. Lee pointed out that membership is a priority project for each state auxiliary. More than recruiting new members, it includes involving and thus retaining members in the organization. The program and scope of each auxiliary should be broad enough to meet the interests and needs of all members, should provide opportunities for leadership development, should offer members a means for participation in meaningful activities in their husband's field of service. Growth must take place on the county level. County auxiliaries should not be overwhelmed with a multitude of projects, but should narrow their aims according to the needs of their communities.

A program on "Leadership and Parliamentary Procedure" was presented at the joint dinner for all those attending the workshops. The speakers were Mrs. Chenault, Mrs. R. C. L. Robertson, and Mrs. Herbert L. Mantz. Members of the AMA staff, assistant directors of Field Service and AMPAC were also present to serve as resource and to discuss pertinent and timely AMA activities and projects.

The Maryland Auxiliary representatives found the Regional Workshop very worthwhile and were very much impressed by the group discussions, exchanges of ideas, instruction programs and lectures.

On November 3, 1969, following a Board Meeting at Med-Chi, "Mini" workshops were held for component auxiliaries' chairmen of AMA-ERF, Children and Youth, Health Careers, Legislation, and Membership committees, at which time the Maryland State chairmen attempted to impart their enthusiasm and information garnered from the Regional Workshop to their counterparts in the component auxiliaries.

Mrs. Wallace H. Sadowsky

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Maryland State department of health

National Registry For Congenital Rubella Syndrome

With the recent licensing of a live attenuated rubella virus vaccine, the eradication of congenital rubella should be attained in the near future. In order to evaluate the effect of rubella immunization programs on the occurrence of congenital rubella, the National Communicable Disease Center recently established a Nationwide Registry to obtain information on children born with this affliction and any abnormalities they may have.

The Division of Communicable Diseases of the Maryland State Department of Health and Mental Hygiene fully endorses this Registry and requests the cooperation of all Maryland physicians in reporting clinical and epidemiological data on cases of congenital rubella which they may see in their practices.

Two kinds of information are requested. In order to gain some meaningful measure of the incidence of congenital rubella in the pre-vaccine era, the names of children with congenital rubella born between January 1, 1966, and September, 1969, should be submitted. Other information such as address, sex, race, date of birth, date of diagnosis, major handicaps, confirmatory laboratory studies, and reporting official should be included. The report can be completed on the usual Communicable Disease Report Card (CD-1) and sent to the local county health departments.

For children born with suspect congenital rubella after September, 1969, the same report card and information should be submitted. However, since more detailed information is requested on these children, a special form with a stamped return envelope will be mailed to each physician reporting a suspect case born after September, 1969.

The Bureau of Laboratories of the State Health Department is prepared to perform appropriate laboratory tests to confirm the presence of congenital rubella. For further information, please call or write the Division of Communicable Diseases, Maryland State Health Department, 301 W. Preston Street, Baltimore, Md. 21201 (301-383-3010, ext. 8406).

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(Continued from page 35)

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	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8						PEDIATRIC GRAND ROUNDS J.H.H.
9			LECTURE REPLAY			
AM 10						
11						MEDICAL GRAND ROUNDS J.H.H.
11:30		MEDICAL GRAND ROUNDS U. OF M.				
NOON 12			C.P.C. J.H.H.			
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rehabilitation notes

History of Treatment of Spinal Cord Injuries

The modern era in medicine can be said to have started with clinical-pathological correlations. In Baltimore, the first physician to report a series of such correlations was Thomas H. Wright, MD (- 1856), physician to the Alms House. Between 1828 and 1833, he presented a series of articles in the newly founded *American Journal of the Medical Sciences.* These articles consist of case reports followed by a review of current knowledge on the particular disease. They reveal the contemporary use of the history, physical examination, laboratory, drugs, and the state of the gross autopsy at the time.

Quadraplegia in 1827

Dr. Wright's first case report [1] is that of a young girl with a fracture-dislocation between C5 and C6, with complete transection of the spinal cord.

The following communications are simply hospital reports, or a plain record of such cases and results, as seemed of sufficient interest to deserve attention, or were calculated to illustrate some principle, or establish some fact of useful application.

Case 1. Paralysis. Subluxation and Fracture of one of the Cervical Vertebrae.—Priscilla Hilton was admitted into the Baltimore Alms-house, November 14th, 1827, with nearly total paralysis of both superior and inferior extremities. The history obtained of the case was as follows:—A week previous to admission, the patient had fallen down a long flight of stairs, striking, as was supposed, on the back of her neck. The accident was not immediately discovered, and the young woman lay for some time insensible. When found by the family, her consciousness had returned, but she was unable to rise, or to use any of her limbs. From that time the paralysis continued, as when admitted in the Alms-house, nearly total.

In connexion with the general paralysis existing when this patient was admitted, there was a tumid tense state of the abdomen, resembling tympanitis. The bowels were torpid, not having acted since the injury, but from medicinal excitement; the flow of urine free, but altogether involuntary; pulse slow and soft, heat natural, respiration unembarrassed, senses perfect, no pain, but tenderness of the abdomen. On examining the neck of the patient, there was some degree of swelling, and great sensibility to pressure. The head was turned and fixed so as to direct the face somewhat to the left side, and all attempts to restore its natural position gave pain, and was resisted by the patient. She preferred being placed on the right side. **Diagnosis.** *Subluxation, and probably fracture of the fifth or sixth cervical vertebra.*

After this patient had been a day or two in the infirmary, she was observed to sleep naturally for some hours at a time, but was liable to be aroused by spasmodic attacks, and was once or twice affected by convulsive muscular action so violent as to throw her out of bed. She had little appetite, and it was found that efforts to vomit generally ensued

a few hours after eating; the egesta commonly green and foetid. On the third day after her admission the tendency to vomiting became greater; every thing swallowed was soon rejected, and stercoraceous matter in considerable quantity became at last mingled with other substances thrown off by the stomach. The attempts to procure intestinal evacuations by the usual cathartics, with enemata, having failed, Croton oil was ordered, in combination with tinct. rhei and ol. ricini. ℞ Ol. Croton. gutt. ij.—Tinct. rhei. ʒiv.—Ol. ricini, ʒj. ft. mist.—ʒiij. om. hora donec alvus movetur sumendus. The first dose suppressed the vomiting; the second procured two or three sufficient alvine movements. The vomiting did not again occur, and the tympanitic state of the abdomen relaxed very much. But the patient manifested an increased state of prostration, and notwithstanding the liberal use of cordials, gradually sunk, and expired on the following day, the fourth after admission. The mental functions continued free from disorder to the last moment.

A careful dissection disclosed the following circumstances. The entire cervical, and part of the dorsal spine, was cautiously exposed, and the vertebrae freed from muscular matter. It was then obvious that there existed partial dislocation, with fracture, at the junction of the fifth and sixth cervical vertebrae. The inferior anterior margin of the fifth cervical vertebra projected four or five lines in advance of the margin and body of the sixth vertebra. The ligament of the left transverse process of the fifth vertebra was torn up, the articular surface exposed, and the process itself dislocated, and partially separated from the body of the vertebra by fracture. The whole cervical column, above the point of injury, was turned or twisted from right to left, so as to present the range or line of its spinous processes, considerably to the right of the line of the same processes in the column below. Hence the turn of the head and left aspect of the face, noticed as existing when the patient was admitted. The theca spinalis was surrounded, the vertebral canal filled, some distance above and below the point of injury, with semifluid grumous blood. The three lower cervical and first dorsal nerves at their exit between the vertebrae were covered and deeply coloured by the same bloody effusion, and the ligament around the injured articulation stained and blackened by the same matter.

The history of the preceding case, with the facts disclosed by dissection, serves to illustrate some of the doctrines of the nervous functions predicated on physiological anatomy, and concurs with the pathological data inculcated by eminent modern surgeons, in reference to injuries of the spinal column, more especially in regard to injuries of the cervical spine, as determined in their nature and effects by the particular point and location of such injury. In the case above recited, the lesion occurred between the fifth and sixth vertebrae, and voluntary motion was almost wholly extinguished in all the muscles supplied by nerves communicating with the spinal marrow below the point of injury. But respiration was not seriously impaired, indeed not sensibly embarrassed, because the nerves holding dominion over the more important respiratory apparatus, were not directly involved in the injury, deriving their origin above the seat of lesion. Hence the protraction of life for many days, although the accident was fatal in its nature, chiefly perhaps from its influence upon the gastric and alimentary functions.

There were some peculiarities in the present instance, or a few circumstances not analogous to the phenomena described as usually attendant on cases of similar injury. Some distinguished surgeons mention retention of urine as among the consequences of injury of the dorsal and cervical spine. The opposite state existed in the subject of the preceding account; the urine flowed continually and involuntarily. This incontinence has been found to occur frequently in females under circumstances which usually produce retention of urine in males, a result probably caused by the difference in the relative structure and connexions of the urethra. Surgeons also (Mr. Cooper and others) represent involuntary intestinal evacuations as attendant on injuries of the spinal cord. Obstinate constipation, scarcely to be overcome by the most powerful purgatives, attended every period of the case above reported. There existed also in this case more faculty of sensation in the parts below the injury, than is common, according to surgical authorities, in such lesions. The sensibility of some parts, the trunk especially, was preternaturally great, instead of the torpor and insensibility generally described.

Writers on injuries involving the spinal marrow, speak of a considerable degree of tympanitic affection of the abdomen resulting from such violation, attributing the effect to torpor of the gastro-enteritic functions, from defective nervous excitement. Probably, irritation through the ganglionic system of nerves, may be concerned in producing the effect in question. It has been already noticed that the subject of the foregoing history was apparently tympanitic, the abdomen being prominent and tense. The tension lessened a good deal after the full operation of a cathartic, but the enlargement of the abdomen was not sensibly diminished. The continuance of the latter state was explained by dissection. While cutting out the cervical with part of the dorsal spine, it was observed that when the cavity of the thorax was penetrated, a thin serous fluid flowed out of the chest in great quantity, far more than is ever naturally present in that cavity, or accumulated by mere infiltration or transudation after death. On opening the abdomen afterwards, it was

found filled with water, containing as much fluid as is usually present in the mature state of abdominal dropsy.

Here then was hydrothorax and ascites apparently produced by injuries of the cervical spine, and so rapidly produced as to have been matured in a few days. The effusion would appear to have been strictly the consequence of the spinal injury, because the subject seemed to have been, and reported herself to have been in good health at the time of the accident. How shall this phenomenon be solved. Is it to be considered as the result of the violent shock communicated to the system, embarrassing the natural functions, and determined more particularly on the capillary series of circulation and transmission, or shall it be regarded as the consequence of irritation suddenly devolved on the serous tissues of the abdomen and thorax, analogous to that sub-inflammatory diathesis in those textures, which commonly gives occasion to hydropic effusion?

The abdominal viscera in this subject were generally in a natural state, with the following exception. The coats of the bladder were very much thickened, particularly where the peritoneum is reflected over the fundus vesicae. Besides the morbid density of the coats and peritoneal covering of the bladder, numerous patches of quite black matter, of considerable surface and thickness, were deposited upon both the bladder and its peritoneal covering; those deposited were of various extent, and appeared of recent formation. Many spots or patches of the same melonose substance, were observed on the colon and mesentery.

Comments on the Case

This case shows that the history is concerned with the immediate illness, but that some effort was made to obtain a past history.

Physical examination consisted of observation and palpation of the neck, abdomen, and pulse. The skin was felt to see whether the patient was febrile. Respirations were observed. Notation of her mental status was made. Observations of her urinary and bowel output were carefully noted and treatment with Croton oil was directed toward her abdominal distension. The postmortem examination concentrated on examination of the cervical vertebrae and the cord.

In his discussion, Dr. Wright shows a good knowledge of the innervation of the muscles to the extremities and of the diaphragm. He notes that some patients with cord injuries had urinary retention, but felt that this was more common in men because of the structure of the urethra. He was particularly interested in the tympanites. He felt that death might have been caused by "defective nervous excitement" of the abdominal nerves. A second finding of interest was hydrothorax and ascites which he considered a consequence of the "violent shock communicated to the system" by the spinal cord injury. Finally, he mentions thickening of the coat of the bladder where black deposits were present, both on the bladder and on the peritoneal covering. These spots were also present over the colon and mesentery.

The cause of death in this patient is not clear from the protocol. We know now that pulmonary embolus, respiratory failure, and severe pulmonary edema frequently contribute to early death in patients with high cervical injuries. In chronic paraplegia, renal failure associated with pyelonephritis and amyloid disease is the most common cause of death. The only treatment given this patient was directed toward bowel movements. Enemata and light cathartics were unsuccessful; however, Croton oil was administered with good results.

This case demonstrates that, at the time, no effective therapy was available for treating these patients.

It was not until 1833, and again in 1836 *(London Medical Gazette)*, that Curling gave detailed study to and described the results of infection on the bladder and kidney in paraplegics. He recognized that survival was related to severity of infection. In 1856 and 1858 *(Guy's Hospital Reports)*, William Gull added more detail to the description of the kidneys. By 1900, the chief causes of death in chronic paraplegia were established as renal failure associated with infection, bed sores, and amyloidosis, or a combination of these factors. The First World War added few advances in the understanding or treatment of patients with spinal cord injuries. After World War I, however, attention was directed toward treatment of the bladder and urinary tract in such patients.

Quadraplegia in 1930

The following case demonstrates the state of treating spinal cord injuries more than 100 years after Dr. Wright's report.

MWP (CH 2730), the first quadraplegic patient seen by the author, was a 17-year-old white boy who suffered a posterior fracture-dislocation of C5 on C6, with complete transection of the spinal cord, after diving into shallow water at the seashore on July 20, 1930. He experienced immediate numbness and loss of motor power in his legs, and a partial loss in his arms. Examination at a local acute hospital revealed clammy hands, loss of sensation below C6, and loss of motor power in the lower extremities. He was unable to initiate micturition, and could not control his bowels. He was treated

with head traction, and given an indwelling catheter, mineral oil, and a daily enema. He developed a small sacral ulcer.

On January 5, 1931, he was transferred to a local children's hospital. His neurological examination showed no detectable changes. Over the next six years, his condition remained the same. He had intermittent fever usually associated with urinary tract infections, and repeated episodes of headaches, sweating, nausea, and vomiting when catheter drainage was obstructed. The catheter was changed weekly; he was helped into a wheelchair and learned to feed himself and perform some simple diversional activities. Over the next few years, the blood non-protein nitrogen gradually rose. On July 22, 1933, he had a suprapubic catheter placed, in an attempt to prevent recurrent urinary tract infections. On November 20, 1934, an intravenous pyelogram showed tremendous hydro-ureters and hydronephrosis on both sides. Thereafter, he gradually developed increasing levels of non-protein nitrogen, and died of uremic poisoning on March 13, 1937.

Postmortem examination showed a healed decubitus ulcer and numerous small decubitus ulcers over the lower back. The spinal column and cord were extensively examined. There was a posterior luxation of C5 on C6. The cord was atrophic below this level. The kidneys were uniformly peppered with small abscesses, the largest being about 1.5 cm in diameter. There were small calculi in both pelvises. The calyces were greatly dilated and the cortex of the kidneys was thin. The ureters were dilated, and the bladder wall, about 1 cm in thickness, was chronically infected. The capacity of the bladder was 30 cc. Microscopic examination of the kidneys showed chronic pyelonephritis and abscess formation. The liver was normal. There was moderate chronic prostatitis. The bladder wall was enormously thickened with infiltration of leukocytes. The spinal cord was degenerated below C5.

Comments on the Case

This is an example of superior care of a traumatic quadriplegic in the pre-antibiotic days. One small sacral ulcer developed in the acute hospital where the patient was first hospitalized, but it was healed by good nursing care without Stryker frame, grafting, or other modern methods. Small ulcers appeared very late in the course of the injury, when the patient was uremic, but decubitus ulcers were not a major problem. No neurosurgical or orthopedic procedures were performed other than head traction. Treatment of the urinary tract was accomplished merely by insuring free drainage of the bladder. With these simple procedures, the patient survived nearly seven years.

Conclusion

Thompson-Walker's work with British soldiers in the first World War [2] showed that of 339 patients with spinal injuries, 160 died of urinary infection eight to ten weeks after admission to a hospital. In 1937,[3] he estimated the total mortality rate from urinary sepsis to be 80%. He noted that an acute hemorrhagic cystitis often led to a septic pyelonephritis early after admission, followed by death within a week. Acute exacerbations of septic pyelonephritis occurred in patients living for longer periods.

Frazier and Allen [4] describe 442 deaths in 717 American soldiers with spinal injuries in 1918. Estimates for the death rate in the American soldiers were similar to those of Thompson-Walker. About 80% died within the first few weeks as a result of infection, bed sores, and catheterization.

The modern era in treatment of spinal cord injuries started with Munro's work in 1943. Munro [5] reported on the use of tidal drainage and stated that "death from genito-urinary sepsis would not be countenanced in my service." The now classic work of Sir Ludwig Guttmann [6] in 1944, together with the introduction of antibiotics, greatly improved the survival of patients who suffered spinal cord injuries in World War II.

REFERENCES

1. Wright, Thomas H.: Reports of Cases Treated in the Baltimore Alms-house Infirmary, *Am J Med Sci* **3**:15, 1828.
2. Thompson-Walker, John: The Bladder in Gunshot and Other Injuries of the Spinal Cord, *Lancet* **1**:173, 1917.
3. Thompson-Walker, John: The Treatment of the Bladder in Spinal Injuries in War, *Brit J Urol* **9**:217, 1937.
4. Frazier, C. H., and Allen, A. R.: *Surgery of the Spine and Spinal Cord*, New York: Appleton, 1918.
5. Munro, D.: Thoracic and Lumbrosacral Cord Injuries, *JAMA* **122**:1055, 1946.
6. Guttmann, L.: The Treatment and Rehabilitation of Patients With Injuries of the Spinal Cord, *Surgery*, Z. Cope (ed.), London: Her Majesty's Stationery Office, 1953, pp 422-516.



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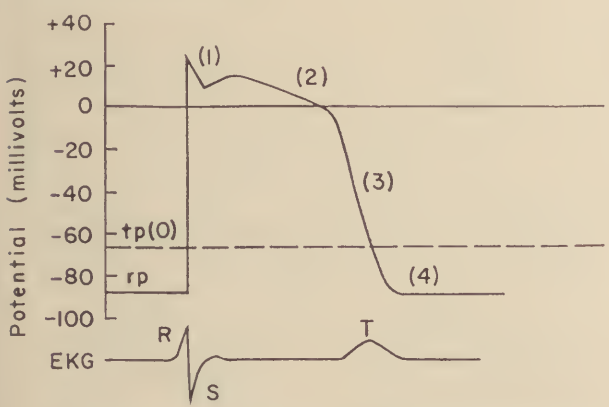
the heart page

Part 2

The Electrocardiogram in Clinical Alterations of Potassium Homeostasis

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In K^+ depletion, there is a marked increase in the duration of phase 3 (MAP) so that the repolarization slope changes from a convex to concave configuration and a significant part of repolarization (last portion of "electrical systole") shifts into phase 4 ("electrical diastole").



Contrary to earlier beliefs, no significant change occurs in the duration of any of the measured EKG intervals, but there are significant changes in voltage and configuration of the ST segments as well as the T and U waves. In general, when $[K^+]$ is at, or slightly below 3.0 me/1 ("moderate K^+ depletion") a relatively small number (10%) of patients display characteristic EKG changes. When $[K^+]<2$ me/1 ("advanced K^+ depletion") $>80\%$ of patients have characteristic changes in EKG. The most consistent change is the appearance of a prominent U wave. An absolute increase in amplitude of 1mm or more in a limb lead (generally II but, occasionally, III or AVF) and especially in the precordial leads which normally reveal tallest waves (usually V3 but occasionally V2 or V4) is characteristic (often higher than the T in that lead). As K^+ depletion progresses there is lowering of the ascending limb of the T wave; as long as a portion of T wave remains upright, ST remains either isoelectric or may "sag" with an upward concavity. As the T becomes progressively lower the ratio of U to T wave amplitude exceeds 1. Simultaneous operation of decreasing T and increasing U waves may go through a variable sequence of changes with U and T waves of equal amplitude ("double humped" contour of bactrian camel) sometimes followed by or associated with a notch of T (rendering a "triple contour" similar to a rolling countryside), followed by U wave growing at the expense of T wave. The ST segment "sagging" gradually becomes obviously depressed (0.5mm) and the concavity of the ST segment is directed downward, especially as T becomes more apparently inverted. Therefore, the most typical pattern of K^+ depletion is a U wave of increased voltage associated with an ST segment and T wave of opposite polarity to the U wave; this appearance has been compared

with a letter "S" lying on its side and is characteristically seen in V_3-V_4. When there is some doubt whether the second of a pair of summits is a T or U wave, the time interval between summits is useful —if <40% of the time from the beginning of the QRS to the second summit, it is a T wave. Most other conditions that simulate the electrocardiographic findings of K^+ depletion can be distinguished on clinical grounds. In tachycardias without K^+ depletion (often associated with ST depression, low T waves), the U wave also tends to diminish in amplitude unless there is associated K^+ depletion (with its attendant prominent U waves). In the latter circumstance, the superimposition of the subsequent P wave (which becomes tilted because its onset is farther from the baseline than its end) is often a clue. Certain conditions (such as cerebrovascular accidents and bradycardias) may be associated with an increased U wave amplitude without K^+ depletion but, under these clinical circumstances, there is apt to be an increase in amplitude of the T wave and the U/T ratio remains <1. When left ventricular preponderance is associated with increased U wave amplitude and ST segment depression, the ST segment is usually elevated in V1-V3 if K^+ depletion is not present. If the latter is present, ST segment will be depressed in V1-V3. ST segment depression alone can be caused by many circumstances other than K^+ depletion (such as digitalis) but an increased U wave amplitude is not apt to be noted. Since quinidine therapy is often associated with an increased U wave amplitude (and this may be true of other anti-arrhythmic agents) and is sometimes given in association with digitalis, an electrocardiographic diagnosis without supplementary clinical information is not possible. Diminished $[K^+]$ enhances automaticity of ectopic supraventricular and ventricular pacemakers and prolongs AV conduction (both of which are enhanced by digitalis and by variable degrees of structural changes brought about by diseases that damage the conducting system). In general, however, the arrhythmias that often occur in association with potassium depletion are attributable to the latter factors and, although common in experimentally induced potassium depletion states, are uncommonly seen in the clinic. Interesting isolated cases of impaired AV conduction in familial periodic paralysis have been reported and favorable response to Atropine has raised the possibility that K^+ depletion may have exerted its effect by altering vagal tone.

Since renal failure is usually present in K^+ intoxication, the role of extracellular concentration of other ions (especially Na^+) often must be considered. It is well to remember that with ↓ $[Na^+]$ EKG changes of potassium intoxication are apt to be seen at levels <7 me/L whereas with normal $[Na^+]$ changes are not apt to be seen at these levels and with an ↑ $[Na^+]$ changes are not likely to be seen at levels of $[K^+]$ <7.5 me/L. Furthermore, the changes of K^+ intoxication are often augmented by an associated clinical state of acidosis and ↓ $[Ca^{++}]$ (commonly seen in terminal renal disease) and diminished by treatment with NSS, glucose, HCO_3, insulin, and Ca^+. When $[K^+]$ >6 me/L, there is an increased permeability of the cell membrane to K^+ associated with K^+ efflux, an increased velocity and slope of phase 3 of MAP and a decreased duration of a repolarization. The earliest electrocardiographic manifestation of this "accelerated repolarization" is the presence of narrow more symmetric tented peaked T waves (sometimes of greater amplitude than the preceding "R" waves); shortened T wave duration and diminished amplitude of the U wave also become evident. The peaked T waves are most often seen in II, III, V_2-V_4 (in children or young adults with normally inverted T waves in V_2-V_3, the T is apt to become more sharply inverted). When serum Na^+ is normal, the peaked T waves are apt to be seen between 7-8 me/L (although sometimes at lower concentrations). These T waves are characteristically symmetric with a low or normal ST junction and the ascending and descending limbs are of the same contour causing the tent-like shape. This is in contradistinction to the tall precordial T waves in normal young people (especially athletes in training); under these circumstances the T wave tends to be asymmetric with elevation of ST junction and the ascending limb of T is less steep than the descending limb. Peaked T waves are also seen in association with acute myocardial ischemia (especially of the posterior and posterolateral left ventricular wall probably related to the observed transient increase of K^+ in coronary sinus blood related to local release of intracellular K^+ by breakdown of ischemic muscle fibers), conditions of left ventricular diastolic "overload" and cerebrovascular accident accidents; all of these conditions are apt to be associated with prolongation of QT_c (which is normal or ↓ when peaked T waves are the only EKG finding in K^+ intoxication) and the clinical diagnosis is usually obvious. Other conditions associated with peaked T waves (supraventricular tachycardia, bradycardia, intermediate stages between flattened and normal T in occasional patients recovering from acute rheumatic carditis) are also usually diagnosed at the bedside. When the level of $[K^+]$ approaches 7 me/L, some QRS widening tends to appear and its progression is well correlated with subsequent further ↑ $[K^+]$ because there is a progressive ↓ in rp and upstroke velocity (phase O, MAP) with attendant slowing of intraventricular conduction. Because there is depressed conduction throughout the myocardium (rather than a focal bundle branch) uniform widening of the QRS is seen with alteration of both initial and terminal

portions. Accordingly, wide S in "left precordial" leads differentiates the QRS from those of typical LBBB and the wide initial portion helps to distinguish from typical RBBB. A combination of tall symmetric peaked T waves with a wide QRS and the presence of S waves in the "left precordial" leads is quite suggestive of K^+ intoxication and may account for the high degree of diagnostic accuracy in some studies. As $[K^+]$ exceeds 7 me/L, the duration of P ↑ and its amplitude ↓. As $[K^+]$ approaches 8-9 me/L there is suppression of diastolic repolarization (phase 4, MAP) of pacemaker fibers and therefore more time is needed to reach tp and, by keeping diastolic repolarization at a potential more negative than tp, sufficient slowing of diastolic repolarization can occur to bring about complete suppression of pacemaker activity. The disappearance of P at time when QRS is still reasonably defined supports the notion that non-specialized atrial fiber excitability is abolished at lower $[K^+]$ levels than ventricular fibers. The disappearance of the P wave also renders AV conduction disturbances of little diagnostic significance in K^+ intoxication since, when $[K^+] > 9$ me/L more obvious changes in QRS have occurred; the normal angularity of QRS has given way to a sinusoidal QRS-T. At $[K^+]$ 12-14 me/L ventricular fibrillation (often heralded by ↑QRS of > 50%) or asystole (especially when ↑ in $[K^+]$ has been slow) ensues.

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Index to Vol. 18,

Maryland State Medical Journal

January-December, 1969

SUBJECT INDEX

Abdomen

FERRER, RO: Wound disruption after abdominal laparotomies (Oct) 57-60

Adolescent

BRACELAND, FJ, DL FARNSWORTH: Depression in adolescents and college students (Apr) 67-73

DEBUSKEY, M: Medical problems of the adolescent (Jan) 55-59

FRIEND, DG: Addiction, psychodelic experimentation and abuse of drugs by the concerned generation (Apr) 59-66

GLASER, K: Emotional problems of adolescents (Jan) 51-54

GLASS, SD: The adolescent patient: an overview (Apr) 48-52

GODENNE, GD: The adolescent turmoil (Sept) 72-74

MASTERSON, JF, JR: Implications of the sex revolution in the adolescent's search for sexual identity (Apr) 53-58

MEAD, M: The changing status of adolescents in the modern world (Nov) 61-64

Prominent "Disease of the '60s" (Jan) 50

YOUSEN, HL, L GORDIS: A comprehensive approach to obstetrical problems of adolescence (Jan) 60-62

Alcoholism

ANDERSON, RH: The alcoholic in the emergency room (July) 101-04

A physician considers his responsibility for treating alcoholics (Jan) 103-05

BERMAN, MI: Alcoholism—obesity "sans" teeth? (Mar) 56-58

Guidelines for admission of alcohol-dependent patients to general hospitals (Dec) 95-96

HITCHMAN, IL: Doctor, do you ever discuss driving with your patients? (Jan) 65

Management of acute phases of alcoholism, including delirium tremens (Mar) 105-07

Medical team sketches portrait of alcoholic (June) 117-18

Memo (Feb) 79-81

SCHMIDHOFER, E: Alcoholism is NOT a disease (Mar) 59-64

Arthritis

CARROLL, DG: Rehabilitation of patients with rheumatoid arthritis (Mar) 71-75

GETTES, NI: Osteoarthritis of the hip (June) 119-21

RILEY, LH, JR: Various pain syndromes which may result from osteoarthritis of the cervical spine (May) 103-05

SOWA, JM: A therapeutic approach to osteoarthritis (Apr) 97-99

Athletics

GROSSMAN, MS: Medical aspects of the obese child in athletics (Aug) 83-5

MAGANZINI, HC: Weight control in athletes (Aug) 76-80

ROBINSON, HM, JR: Skin problems in athletes (Aug) 81-82

Blood

ADAMS, JE: Innovations in blood procurement (Jan) 79-80

Community blood resource program (Mar) 91-93

Federal action against pooled plasma (May) 113-14

Brain

BALDWIN, RW: Behavior disorders in children (Sept) 68-71

Cancer

RADMAN, HM: Sarcoma botryoides (May) 80-83

SAWADA, EA: Editorial: American Cancer Society, Maryland Division, Inc, (Sept) 60-61

SEYDEL, HG, J MAUN: Pulmonary fibrosis following radiotherapy for bronchogenic carcinoma and Hodgkin's disease (Oct) 61-2

SOLOMON, BA: Preliminary report on the dietary management of patients with advanced carcinoma (May) 77-79

Cephaloridine

WALKER, SH, VT MAISOG: Cephaloridine dosage in infants and children (Nov) 65-69

Clergy

Clergy-physician dialogues (July) 77-84

Cold

Exposure to cold environment and rhinovirus common cold (Mar) 115-16

Community

Some medical and social problems of the urban community (Sept) 80-82

Diabetes

ZEICHNER, IB: A man named Tufti (Nov) 107-09

Drugs

CARSON, JE, K GORWITZ: On the hospitalization of drug addicts (Aug) 104

DOBRZYCKI, GD: Drugs and driving (May) 101-02

FRIEND, DG: Addiction, psychodelic experimentation and abuse of drugs by the concerned generation (Apr) 59-66

HEAD, M: The drug issue (Sept) 63-64

PEEPLES, WJ: Comparative price list: generic vs brand name drugs (July) 89-91

WILSON, EF, RS FISHER: Death from narcotics use: Baltimore City, 1963 through 1968 (Oct) 48-52

Editorial

SAWADA, EA: American Cancer Society, Maryland Division, Inc. (Sept) 60-61

Education

JARBOE, JP: What's in a preceptorship? for the physician (Mar) 52

WILSON, J: What's in a preceptorship? for the student (Mar) 53-55

Emergency

BEAVEN, WE, JF SORDO, P WHELTLE: Emergency room problems of an "Inner Core" city hospital (Oct) 63-67

STEARNS, P: Emergency medical services (Apr) 115

Ethics

AMA, Better Business Bureau: decade of cooperatively combating quackery (Jan) 17

Ethics corner (Mar) 130

Executive Secretary (newsletter)

SARGEANT, J:

(Jan) 9-10
(Feb) 9-10
(Mar) 9-10
(Apr) 13-14
(May) 9-10
(June) 9-10
(July) 9-10
(Aug) 9-10
(Sept) 9-10
(Oct) 9-10
(Nov) 9-10
(Dec) 9-10

Eyes

BARR, SE: Are your patient's eyes fit for driving a car? (Mar) 125

Family

PEEPLES, WJ: Federal grant approved for family planning program (Sept) 109

Geriatrics

FARBER, RE: Evaluation service for the elderly (Sept) 91

PATTERSON, RD: Grief and depression in old people (Sept) 75-79

SPENCER, J: The management of behavior disorders in the geriatric patient (May) 73-76

Head

MURPHY, JP: Occipital neurectomy in the treatment of headache (June) 62-66

Health Services

FARBER, RE: (Baltimore City Health Department) Baltimore's health in 1968 (Mar) 83-86

Health news (Apr) 103-04; (Oct) 89; (Nov) 91; (Dec) 91

New sanitary enforcement program (Aug) 101

PEEPLES, WJ: (State of Maryland Department of Health) see also subjects

Comparative price list: generic vs brand name drugs (July) 89-91

Federal grant approved for family planning program (Sep) 109

Highlights (Jan) 81-82; (Apr) 109-10; (Aug) 91

Influenza (Mar) 121

Measles morbidity in Maryland (May) 99

Medical assistance advisory committee (Nov) 97

Heart

AWALT, LF: Effect of other drugs on oral anticoagulants (Oct) 103-04

BARTH, WF: Cardiac amyloidosis (Jan) 83-84

COHEN, ML, RD BIGGS: Artificial cardiac pacing—current status (July) 87-88

CURRY, JJ: Electrodes for cardiac monitoring in the coronary care unit (Dec) 69-72

LINFIART, JW: Evaluation of left ventricular myocardial function in patients undergoing cardiac surgery (Feb) 63-64

MESSINA, JJ: Wolff-Parkinson-White syndrome (Apr) 105-07

MISANIK, LF: Lipoprotein phenotypes (Sep) 103-05

PAPADOPOULOS, C: Arrhythmias in myocardial infarction (Aug) 93-95

PARSOUNET, V: Present status of permanent pacing of the heart (Feb) 57-8

RAPOPORT, MI, R SABUNDAYO: Antibiotic chemoprophylaxis in cardiac surgery (June) 129-30

ROBINSON, NA: Clinical uses of central venous pressure (Dec) 73-74

SCHERLIS, S: Recognizing the acute coronary process (Mar) 87-89

STAMPFER, M, SE EPSTEIN: Clinical applications of inhibition of Beta-adrenergic receptors with propranolol (Feb) 61-62

WEBER, R: The electrocardiogram in clinical alterations of potassium homeostasis: Part I (Dec) 103-04

WILDER, RJ: The cardiac patient and driving (June) 29-30

Hodgkin's Disease

SEYDEL, HG, J MAUN: Pulmonary fibrosis following radiotherapy for bronchogenic carcinoma and Hodgkin's disease (Oct) 61-62

Hospitals

BEAVEN, WE, JF SORDO, P WHELTLE: Emergency room problems of an "Inner Core" city hospital (Oct) 63-67

Insight into escalating hospital costs (Jan) 114

Influenza

PEEPLES, WJ: Influenza (Mar) 121

Interpretation

List of interpreters (Sep) 43-45

Kidney

BORMEL, P: Renal homotransplantation (May) 68-72

HEPTINSTALL, RH: Renal biopsy (July) 105-06

OLLODART, RM: Reasons for renal allograft success as compared to heart transplants (Nov) 105-06

STEWART, BH, RA STRAFFONS: Human kidney transplantation (May) 61-67

Leukemia

FEHETY, FR, JR, JJH CAREY: Season and the onset of acute childhood leukemia (Nov) 73-77, 82

Library, Medical and Chirurgical Faculty

(Jan) 30-31, 91-93
(Feb) 89-90, 99
(Mar) 16-17, 117-19
(Apr) 17-18, 121-23
(May) 27-29
(June) 16, 33
(July) 107-09
(Aug) 97-98, 102-03
(Sept) 18-19, 115-17
(Oct) 26-27, 117-20
(Nov) 35, 89-90
(Dec) 35-36

Measles

PEEPLES, WJ: Measles morbidity in Maryland (May) 99

Recommendations for the use of Rubella vaccine (Aug) 13

Medic

Medic Schedule 1969-70: (Jan) 27-28; (Feb) 25-26; (Mar) 33-34; (Apr) 29-30; (Oct) 33-34; (Nov) 47-48; (Dec) 30-31

Medical and Chirurgical Faculty of the State of Maryland

Annual Meeting, 171st (Jan) 25-26; (Feb) 23-24; (Mar) 27-29

Annual statement of finances (July) 47-60

Annual reports to House of Delegates (June) 67-107

Minutes, annual meeting (June) 35-44

SARGEANT, J: Your medical faculty at work

(Jan) 63 (July) 85
(Feb) 65-66 (Aug) 86-88
(Mar) 65-70 (Sep) 83-84
(Apr) 75-77 (Oct) 68-69
(May) 89-90 (Nov) 78
(June) 108 (Dec) 87

SERGEANT, JB: What's in a name? (May) 59

Semiannual meeting highlights (Dec) 56-57

Semiannual meeting news (Dec) 58-60

Transactions, semiannual meeting (Med-Chi) (Dec) 105-07

Transactions, semiannual meeting (AMA) (Dec) 108-12

Medical Examiners, Board of

Directory of registered physicians (Apr) 25-28; (Dec) 45-48

Medical News

(Jan) 37-38 (July) 68-74
(Feb) 43-45 (Aug) 45-48
(Mar) 49-51 (Sep) 46-49
(Apr) 79-81 (Oct) 35-37
(May) 51-54 (Nov) 49-51
(June) 49-53 (Dec) 54-55

The month in Washington

(Jan) 33-35 (July) 27-30
(Feb) 31-32 (Aug) 31-34
(Apr) 88-90 (Sep) 26-29
(May) 19-21 (Oct) 107-09
(June) 24-25 (Dec) 51-53

Medical Assistants, Maryland Association of

News (May) 44-47

Medical practice

BAKER, S, T BAKER: Your patient's life—how can you protect it? (Feb) 55

Dysfunctions of the Keogh or what to do until help arrives (Mar) 111-13

Medical Societies, Component

(Jan) 111-12 (July) 35-37
(Feb) 97-98 (Aug) 109-10
(Mar) 31-32, 108-09 (Oct) 81-82
(Apr) 83-85 (Dec) 39-40
(May) 13-17

Meniere's Disease

NACHLAS, NE, M TRAIL: Sacculotomy in the treatment of Meniere's Disease (Oct) 53-56

Mental Hygiene

CARSON, JE, K GORWITZ: Capacity, patient population size and occupancy rates (Nov) 101

Diagnostic treatment trends (Dec) 89

Fact sheet for 1969 fiscal year (Sep) 89

Highlights (Apr) 100

Is there a revolving door? (Mar) 123

Maryland's privately operated psychiatric hospitals (Jan) 68

National Scene (May) 98

On Baltimore's mental health problems and needs (July) 93

On the care of the mentally subnormal (June) 115

On the hospitalization of drug addicts (Aug) 104

Report to the 15 Southern states (Oct) 105

Voluntary admissions (Feb) 69

GORWITZ, K: Developing meaningful mental health statistics (Oct) 123-26

PHILLIPS, GM: Rising mental health demands, innovative programs and budgetary appropriations (May) 123-24

Mental Retardation

PEEPLES, WJ: Growth of day care centers for the mentally retarded (Oct) 95

Nutrition

FARBER, RE: Malnutrition in Baltimore's children (Jan) 89-90

Mayor's task force on nutrition (June) 111

SCHAFFER, AJ: Nutritional status of C/Y center children (Dec) 83-86

Obesity

GROSSMAN, MS: Medical aspects of the obese child in athletics (Aug) 83-5

MAGANZINI, HC: Weight control in athletes (Aug) 76-80

Obstetrics

LEVIN, N, D TABANAO MAHUSAY: Sickle cell disease in pregnancy (Dec) 75-77

YOUSEM, HL, L GORDIS: Comprehensive approach to obstetrical problems of adolescence (Jan) 60-62

Pathology

SCHAEFFER, JF: Your pathologist is a practicing physician like yourself—be loyal to his local laboratory (June) 60-61

Pediatrics

BALDWIN, RW: Behavior disorders in children (Sep) 68-71

Childhood sarcoidosis (July) 117-18

CORRIGAN, GE: Sudden unexpected death in infants (Nov) 70-72

HALLER, JA: Postoperative management of infants (May) 85-88

Patella (knobby)

News (Dec) 56

Phlebography

DEMARCO, SJ, III: Phlebography in leg complaints (Dec) 78-82

Physical fitness
NORRIS, EN: Measurement of physical fitness (Aug) 70-75

Preceptorship
BERUBE, LW: Preceptorship program of the Maryland Academy of General Practice (Mar) 52-53

Psychiatry
PATTERSON, RD: Grief and depression in old people (Sep) 75-79
SHOCKET, BR: Recognizing the suicidal patient (Sep) 65-67
STEWART, WL: Psychiatry for the family physician (Sep) 62
WEINTRAUB, W: What is a psychiatrist? (July) 75-76

Public Health
GORDON, J: Public health and the conquest of disease in Baltimore, 1792-1968 (May) 95-97

Pulmonary Disease
BLIDE, RW: Pulmonary function testing in the office (Feb) 67-68
Course and prognosis of chronic obstructive lung disease (Aug) 99-100
Residual pulmonary findings in clinical hyaline membrane disease (May) 107-08
RIMINGTON, J: Smoking, sputum, and lung cancer (Jan) 85-86
SAMET, P: Emergency treatment of acute pulmonary edema (Feb) 59-60
SEYDEL, HG, J MAUN: Pulmonary fibrosis following radiotherapy for bronchogenic carcinoma and Hodgkin's disease (Oct) 61-62
SIMPSON, DG: Chronic cor pulmonale (May) 109-11

Rehabilitation
CARROLL, DG: Prediction of performance of patients with hip fracture Part I (Jan) 69-74
Part II (Feb) 83-84
Rehabilitation of patients with rheumatoid arthritis (Mar) 71-75
HSU, JD: Rehabilitation of patients suffering from fracture of the hip Part I (July) 111-12
Part II (Aug) 89-90
Part III (Sep) 85-86
Part IV (Sep) 87
MAHONEY, FI: Rehabilitation of spinal cord injured patients Part I (Oct) 113-16
Part II (Nov) 113-16

Respiratory Disease
Home care of chronic respiratory disease (Oct) 87-88
Survival of acute respiratory failure (Nov) 93-94

Sex
MASTERSON, JF, JR: Implications of the sexual revolution in the adolescent's search for sexual identity (Apr) 53-58
Sex education of children and youth (Sep) 13-14

Skin
ROBINSON, HM, JR: Skin problems in athletes (Aug) 81-82

Spine
BORGES, FJ, AZ STEINBERG, PP MENDONCA: The effect of urinary diversion on urinary tract disease in patients with spinal cord injury (Dec) 113-16
MAHONEY, FI: Rehabilitation of spinal cord injured patients Part I (Oct) 113-16
Part II (Nov) 113-16

Suicide
SHOCKET, BR: Recognizing the suicidal patient (Sep) 65-67

Syphilis
CAVENAUGH, RL: The serologic syphilis test required for marriage in other states (May) 33

Thorax
Childhood sarcoidosis (July) 117-18

Traffic Safety
BAKER, SP: Highway deaths, natural and traumatic (Oct) 45
Man against machine: international accident symposium (Sep) 121-22
BARR, SE: Are your patient's eyes fit for driving a car? (Mar) 125
BREITENECKER, R: Maryland law and the drinking driver (Feb) 49-50
DIGGES, JD: "Implied consent—and what it implies" (Feb) 51-53
DOBRZYCKI, GD: Drugs and driving (May) 101-02
HITCHMAN, IL: Doctor, do you ever discuss driving with your patients? (Jan) 65
SARGEANT, J: Too much, too late (Feb) 46-47
WILDER, RJ: The cardiac patient and driving (June) 29-30

Transplantation
BORMEL, P: Renal homotransplantation (May) 68-72
OLLODART, RM: Reasons for renal allograft success as compared to heart transplants (Nov) 105-6
STEWART, BH, RA STRAFFON: Human kidney transplantation (May) 61-67

Tuberculosis
Treatment of disseminated mycotic infections (Apr) 101-02
Tuberculin testing program (June) 109-10

Urinary Disease
BORGES, FJ, AZ STEINBERG, PP MENDONCA: Effect of urinary diversion on urinary tract disease in patients with spinal cord injury (Dec) 113-16

Virus
Toward control of viral infections of man (Dec) 101-02
Symposium on viral diseases (Oct) 39-40

Woman's Auxiliary
(Jan) 36
(Feb) 91-92
(Mar) 127-28
(Apr) 117-18
(May) 48-49
(Sep) 101-02
(Oct) 101-02
(Nov) 103-04
(Dec) 33-34

Your Family Doctor
FARBER, RE: "Your Family Doctor" celebrates 20 years on TV (Feb) 85-88

AUTHOR INDEX

ADAMS, JE: Innovations in blood procurement (Jan) 79-80

ANDERSON, RH: The alcoholic in the emergency room (July) 101-04

A physician considers his responsibility for treating alcoholics (Jan) 103-05

AWALT, LF: Effect of other drugs on oral anticoagulants (Oct) 103-04

BAKER, S, T BAKER: Your patient's life—how can you protect it? (Feb) 55

BAKER, SP: Highway deaths, natural and traumatic (Oct) 45

Man against machine: international accident symposium (Sep) 121-22

BALDWIN, RW: Behavior disorders in children (Sep) 68-71

BARR, SE: Are your patient's eyes fit for driving a car? (Mar) 125

BARTH, WF: Cardiac amyloidosis (Jan) 83-84

BEAVEN, WE, JF SORDO, P WHELTLE: Emergency room problems of an "Inner Core" city hospital (Oct) 63-67

BERMAN, MI: Alcoholism—obesity "Sans" teeth? (Mar) 56-58

BERUBE, LW: The preceptorship program of the Maryland Academy of General Practice (Mar) 52-53

BIGGS, RD: see ML Cohen

BLIDE, RW: Pulmonary function testing in the office (Feb) 67-68

BORGES, FJ, AZ STEINBERG, PP MENDONCA: The effect of urinary diversion on urinary tract disease in patients with spinal cord injury (Dec) 113-16

BORMEL, P: Renal homotransplantation (May) 68-72

BRACELAND, FJ, DL FARNSWORTH: Depression in adolescents and college students (Apr) 67-73

BREITENECKER, R: Maryland law and the drinking driver (Feb) 49-50

CAREY, JJH: see FR Fehety, Jr.

CARROLL, DG: Prediction of performance of patients with hip fracture Part I (Jan) 69-74

Part II (Feb) 83-84

Rehabilitation of patients with rheumatoid arthritis (Mar) 71-75

CARSON, JE, K GORWITZ: Capacity, patient population size and occupancy rates (Nov) 101

Fact sheet for 1969 fiscal year (Sep) 89

Is there a revolving door? (Mar) 123

Highlights (Apr) 100

Maryland's privately operated psychiatric hospitals (Jan) 68

National scene (May) 98

On Baltimore's mental health problems and needs (July) 93

On the care of the mentally subnormal (June) 115

On the hospitalization of drug addicts (Aug) 104

Report to the 15 Southern states (Oct) 105

Voluntary admissions (Feb) 69

CAVENAUGH, RL: Serologic syphilis test required for marriage in other states (May) 33

COHEN, ML, RD BIGGS: Artificial cardiac pacing—current status (July) 87-8

CORRIGAN, GE: Sudden unexpected death in infants (Nov) 70-72

CURRY, JJ: Electrodes for cardiac monitoring in the coronary care unit (Dec) 69-72

DEBUSKEY, M: Medical problems of the adolescent (Jan) 55-59

DEMARCO, J, III: Phlebography in leg complaints (Dec) 78-82

DIGGES, JD: "Implied" consent and what it implies (Feb) 51-53

DOBRZYCKI, GD: Drugs and driving (May) 101-02

EPSTEIN, SE: see M Stampfer

FARBER, RE: Baltimore's health in 1968 (Mar) 83-86

Evaluation service for the elderly (Sep) 91

Health news (Apr) 103-04; (Oct) 89; (Nov) 91; (Dec) 91

Malnutrition in Baltimore's children (Jan) 89-90

Mayor's task force on nutrition (June) 111

New sanitary enforcement program (Aug) 101

"Your Family Doctor" celebrates 20 years on TV (Feb) 85-88

FARNSWORTH, DL: See FJ Braceland

FEHETY, FR, JR, JJH, CAREY: Season and the onset of acute childhood leukemia (Nov) 73-77, 82

FERRER, RO: Wound disruption after abdominal laparotomies (Oct) 57-60

FISHER, RS: see EF Wilson

FRIEND, DG: Addiction, psychodelic experimentation and abuse of drugs by the concerned generation (Apr) 59-66

GETTES, NI: Osteoarthritis of the hip (June) 119-21

GLASER, K: Emotional problems of adolescents (Jan) 51-54

GLASS, SD: The adolescent patient: an overview (Apr) 48-52

GODENNE, GD: The adolescent turmoil (Sep) 72-74

GORDIS, L: see HL Yousem

GORDON, J: Public health and the conquest of disease in Baltimore, 1792-1968 (May) 95-97

GORWITZ, K: Developing meaningful mental health statistics (Oct) 123-26

GROSSMAN, MS: Medical aspects of the obese child in athletics (Aug) 83-85

HALLER, JS: Postoperative management of infants (May) 85-88

HAYNES, MA: Some medical and sociological problems of the urban community (Sep) 80-82

HEAD, M: The drug issue (Sep) 63-64

HEPTINSTALL, RH: Renal biopsy (July) 105-06

HITCHMAN, IL: Doctor, do you ever discuss driving with your patients? (Jan) 65
HSU, JD: Rehabilitation of patients suffering from fracture of the hip Part I (July) 111-12
Part II (Aug) 89-90
Part III (Sep) 85-86
Part IV (Sep) 87

JARBOE, JP: What's in a preceptorship? for the physician (Mar) 52

LEVIN, N, D TABANAO-MAHUSAY: Sickle cell disease in pregnancy (Dec) 75-77
LINFIART, JW: Evaluation of left ventricular myocardial function in patients undergoing cardiac surgery (Feb) 63-64

MAGANZINI, HC: Weight control in athletes (Aug) 76-80
MAHONEY, FI: Rehabilitation of spinal cord injured patients Part I (Oct) 113-16
Part II (Nov) 113-16
MAISOG, VT: see SH Walker
MASTERSON, JF, JR: Implications of the sexual revolution in adolescent's search for sexual identity (Apr) 53-58
MAUN, J: see HG Seydel
MEAD, M: The changing status of adolescents in the modern world (Nov) 61-4
MENDONCA, PP: see FJ Borges
MESSINA, JJ: Wolff-Parkinson-White syndrome (Apr) 107-07
MISANIK, LF: Lipoprotein phenotypes (Sep) 103-05
MURPHY, JP: Occipital neurectomy in the treatment of headache (June) 62-66

NACHLAS, NE, M TRAIL: Sacculotomy in the treatment of Meniere's disease (Oct) 53-56
NORRIS, EN: Measurement of physical fitness (Aug) 70-75

OLLODART, RM: Reasons for renal allograft success as compared to heart transplants (Nov) 105-06
PAPADOPOULOS, C: Arrhythmias in myocardial infarction (Aug) 93-95
PARSOUNET, V: Present status of permanent pacing of the heart (Feb) 57-58
PATTERSON, RD: Grief and depression in old people (Sep) 75-79
PEEPLES, WJ: Comparative price list: generic vs brand name drugs (July) 89-91
Federal grant approved for family planning program (Sep) 109
Growth of day care centers for the mentally retarded (Oct) 95
Highlights (Jan) 81-82; (Apr) 109-10; (Aug) 91
Influenza (Mar) 121
Measles morbidity in Maryland (May) 99
Medical assistance advisory committee (Nov) 97
PHILLIPS, GM: Rising mental health demands, innovative programs and budgetary appropriations (May) 123-24

RADMAN, HM: Sarcoma botryoides (May) 80-83
RAPOPORT, MI, R SABUNDAYO: Antibiotic chemoprophylaxis in cardiac surgery (June) 129-30
RILEY, LH, JR: Various pain syndromes which may result from osteoarthritis of the cervical spine (May) 103-05
RIMINGTON, J: Smoking, sputum, and lung cancer (Jan) 85-86
ROBINSON, HM, JR: Skin problems in athletes (Aug) 81-82
ROBINSON, NA: Clinical uses of central venous pressure (Dec) 73-74

SABUNDAYO, R: See MI Rapoport
SAMET, P: Emergency treatment of acute pulmonary edema (Feb) 59-60
SARGEANT, J: Executive Secretary's Newsletter:
(Jan) 9-10
(Feb) 9-10
(Mar) 9-10
(Apr) 13-14
(May) 9-10
(June) 9-10
(July) 9-10
(Aug) 9-10
(Sep) 9-10
(Oct) 9-10
(Nov) 9-10
(Dec) 9-10
Too much, too late (editorial) (Feb) 46-47
Your medical faculty at work:
(Jan) 63
(Feb) 65-66
(Mar) 65-70
(Apr) 75-77
(May) 89-90
(June) 108
(July) 85
(Aug) 86-88
(Sep) 83-84
(Oct) 68-69
(Nov) 78
(Dec) 87
SARGEANT, JB: What's in a name? (May) 59
SAWADA, EA: American Cancer Society, Maryland Division, Inc. (Sep) 60-61
SCHAEFFER, JF: Your pathologist is a practicing physician like yourself—be loyal to his local laboratory (June) 60-61
SCHAFFER, AJ: Nutritional status of C/Y center children (Dec) 83-86
SCHERLIS, S: Recognizing the acute coronary process (Mar) 87-89
SCHMIDHOFER, E: Alcoholism is NOT a disease (Mar) 59-64
SEYDEL, HG, J MAUN: Pulmonary fibrosis following radiotherapy for bronchogenic carcinoma and Hodgkin's disease (Oct) 61-62
SHOCKET, BR: Recognizing the suicidal patient (Sep) 65-67
SIMPSON, DG: Chronic cor pulmonale (May) 109-11
SOLOMON, BA: Preliminary report on the dietary management of patients with advanced carcinoma (May) 77-79
SORDO, JF: see WE Beaven
SOWA, JM: Therapeutic approach to osteoarthritis (Apr) 97-99
SPENCER, J: Management of behavior disorders in the geriatric patient (May) 73-76
STAMPFER, M, SE EPSTEIN: Clinical applications of inhibition of Beta-adrenergic receptors with propranolol (Feb) 61-62
STEARNS, P: Emergency medical services (Apr) 115
STEINBERG, AZ: see FJ Borges
STEWART, BH, RA STRAFFON: Human kidney transplantation (May) 61-67
STEWART, WL: Psychiatry for the family physician (Sep) 62
STRAFFON, RA: see BH Stewart

TABANAO-MAHUSAY, D: see N Levin
TRAIL, M: see NE Nachlas

WALKER, SH; VT MAISOG: Cephaloridine dosage in infants and children (Nov) 65-69
WEBER, R: Electrocardiogram in clinical alterations of potassium homeostasis (Part I) (Dec) 103-04
WEIN TRAUB, W: What is a psychiatrist? (July) 75-76
WHELTLE, P: see WE Beaven
WILDER, RJ: Cardiac patient and driving (June) 29-30
WILSON, EF, RS FISHER: Death from narcotics use, Baltimore City, 1963-1968 (Oct) 48-52
WILSON, J: What's in a preceptorship? for the student (Mar) 53-55

YOUSEM, HL, L GORDIS: Comprehensive approach to obstetrical problems of adolescence (Jan) 60-62

ZEICHNER, IB: A man named Tufti (Nov) 107-09

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

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Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

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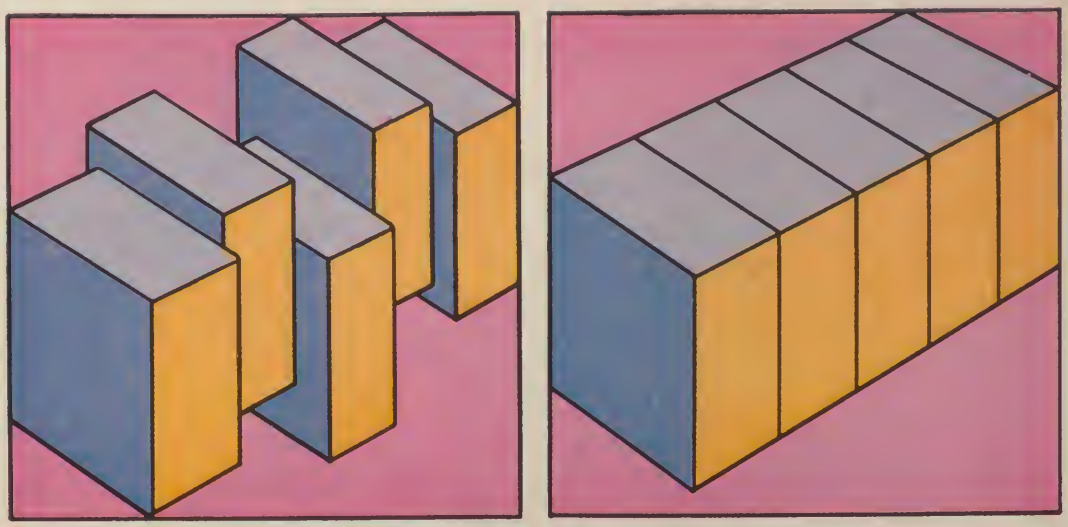
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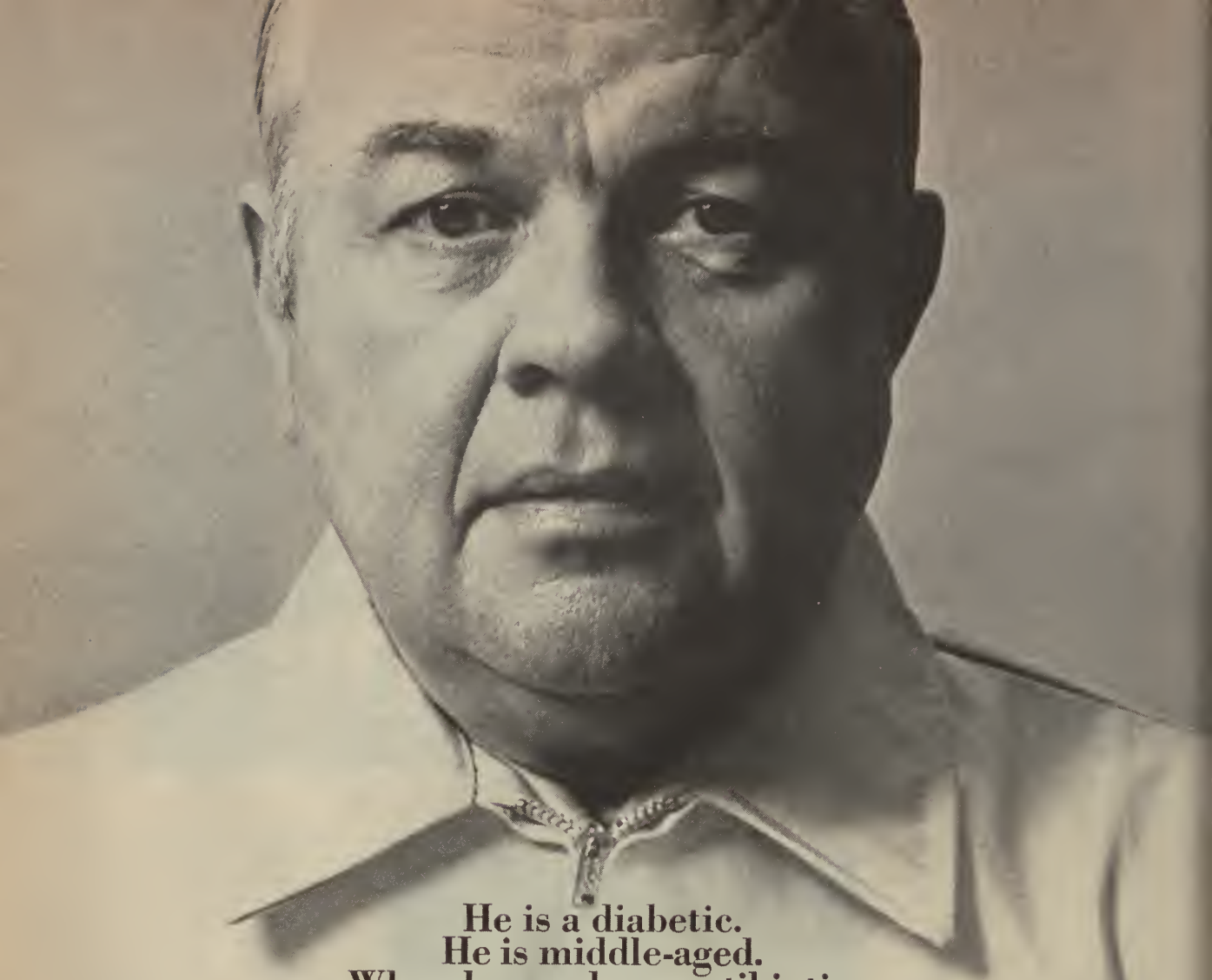
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

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VOLUME 19 FEBRUARY 1970 NUMBER 2

CONTENTS:

Joint Anesthesia Study Committee—Organization and Function, Calbert T. Seebert, MD 46

Anesthesia—1970, Martin I. Gold, MD 48

"The anesthesiologist as a physician has existed for almost 125 years, but it is only within the last few decades that anesthesia has become recognized as a specialty and its beneficial effects appreciated. The primary change has been in the area of the patient's safety. Knowledge of physiology and pharmacology was joined to the technique and administration of anesthetics, and both have matured ino a philosophy of the management of patients under anesthesia."

Predicting the Need for Ventilatory Assistance, Joseph S. Redding, MD, and Ronald W. Yakaitis, MD 53

"Normal man is capable of markedly increasing rate and depth of breathing in response to increased need. This ventilatory reserve may be diminished by anything which impairs function of the neural mechanisms regulating breathing, reduces the mechanical efficiency of the thoracic cage, or increases the resistance to flow in the airways or lungs . . . . The anesthesiologist must be able to anticipate the likelihood of the patient needing postoperative ventilatory support."

Problems in the Management of Drowning Victims, Joseph S. Redding, MD, Ronald W. Yakaitis, MD, and C. Hershel King, MD.. 58

"Over 6,000 people die from drowning each year in the United States. Most of them are young and in good health. No single disease kills as many people under 24 years old. In spite of the magnitude of the problem, relatively little is known about this fatal accident."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 62

Heart Page—The Master's Two-Step Exercise Tolerance Electrocardiograph Test: Part 1, Luis F. Gonzalez, MD 67

Library Page—Professional Conferences 71

Maryland State Department of Mental Hygiene— Length of Hospitalization 75

Maryland State Department of Health—Highlights 81

Tuberculosis—Lung Cancer in Women 85

Baltimore City Health Department—The Reverend Hanna Appointed 87

Alcoholism—Nursing Care for the Alcoholic, Ellen A. Andruzzi, RN 93

Rehabilitation Notes—Orthopedic Aspects of Spinal Cord Injuries, Gerhard Schmeisser, Jr., MD 95

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ON THE COVER: This month's issue is devoted to anesthesiology and our cover design, entitled Aqueous, is an intaglio print executed by **Mrs. Ina Helrich,** wife of Martin Helrich, MD, Anesthesiologist-in-Chief of the University of Maryland.

—0—

Doctors Take Note **5**

Executive Secretary's Newsletter **9**

MEDIC **26**

Orient Tour **29**

Book Reviews **31**

The Month in Washington **33**

Venereal Disease Treatment Schedule **35**

Annual Meeting Program **36**

Annual Meeting Speakers **38**

Annual Meeting Exhibitors **40**

Resolution Regarding Hazards of Cigarette Smoking **62**

Current Reimbursement Policies of the Maryland Medical Assistance Program **63**

Hotel Reservation Coupon **65**

Arts and Hobby Exhibit **66**

Woman's Auxiliary **69**

Library Accessions **72**

Diptheria, Tetanus, and Pertussis Vaccine **83**

Advertising Index **101**

Classified Advertising **102**


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FEBRUARY 25-MARCH 1, 1970
AMERICAN COLLEGE OF CARDIOLOGY

19th Annual Scientific Session: Rivergate Center, New Orleans, La. The session will include major scientific symposia and a special group of panel discussions. For additional information, contact: William D. Nelligan, Executive Director, 9650 Rockville Pike, Bethesda, Md. 20014.

FEBRUARY 28, 1970
SOUTH BALTIMORE GENERAL HOSPITAL

Hand Symposium—On the Management of Acute Hand Diseases: South Baltimore General Hospital, 3001 Hanover St., Baltimore. Main speaker and moderator: Raymond C. Curtis, MD. Participants in the symposium and panel will be Drs. E. Berg, S. Wilgis, G. Clark, F. Hansen, M. A. Sarshar, G. Plaase, C. Tountas, A. Jasion, H. Wilhelmsen, M. Vahos, and L. Salazar. Contact: Neil Novin, MD, South Baltimore General Hospital.

FEBRUARY 28-MARCH 1, 1970
THE AMERICAN BOARD OF FAMILY PRACTICE

First Examination for Certification. Information regarding the examination and eligibility for the examination can be obtained by writing to: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

MARCH 2-4, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Clinical Concepts in Infectious Diseases: Manifestations and Management: University of Florida College of Medicine, Gainesville, Fla. Co-directors: Leighton E. Cluff, MD, FACP; Joseph E. Johnson, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 3, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—New Approaches to Immunosuppression in an Animal Model: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. Speaker: Theodore Lewers, MD.

MARCH 9-13, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Cardiology and Renal Disease: Pathophysiology and Pharmacology: Presbyterian-St. Luke's Hospital, Chicago, Ill. Co-directors: Franklin D. Schwartz, MD; Richard A. Carleton, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 12-14, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course—Recent Developments in Ob & Gyn: Page and William Black Postgraduate School of Medicine, New York, New York. Contact: Page and William Black Postgraduate School of Medicine, 5th Ave. and 100th St., New York, New York 10029.

MARCH 13-15, 1970
AMERICAN PSYCHIATRIC ASSOCIATION COMMITTEE ON PSYCHIATRY AND MEDICAL PRACTICE

9th Colloquium for Postgraduate Teaching of Psychiatry: Sheraton Motor Inn, Portland, Oregon. Participants will be divided into small groups led by physicians familiar with programs of psychiatric education. Registration fee is $50. Contact: American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D.C. 20009.

MARCH 14, 1970
HEART ASSOCIATION OF MARYLAND/MARYLAND ACADEMY OF GENERAL PRACTICE

Symposium—Myocardial Infarction Before and During Hospitalization: 10 AM-4 PM, South Baltimore General Hospital. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201; Mrs. Tyson (301) 685-7074, or Mrs. Holman (301) 661-1925.

MARCH 16-18, 1970
AMERICAN COLLEGE OF SURGEONS

Joint Meeting for Physicians and Nurses: Sheraton-Park Hotel, Washington, D.C. Charles A. Hufnagel, Washington, D.C., heads the planning committee for the surgeons' program, which will include sessions in gynecology and obstetrics, neurosurgery, ophthalmology, otolaryngology, plastic surgery, orthopedic surgery, and urology. Contact: Mr. Thomas E. McGinnis, American College of Surgeons, 55 East Erie, Chicago, Ill.

MARCH 16-20, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Clinical Problems in Internal Medicine: Cleveland Clinic, Cleveland, Ohio. Director: H. S. Van Ordstrand, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 16-27, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course in Obstetrics and Gynecology: Harvard Medical School, Boston. Contact: Harvard Medical School, Department of Continuing Education, 25 Shattuck St., Boston, Mass 02115.

MARCH 17, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Mechanisms of Renal Control of Sodium Excretion: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Speaker: Alfonso Janoski, MD.

MARCH 18, 1970
MARYLAND KIDNEY FOUNDATION

Seminar—The Biomedical Applications of Collagen: Its Use in Transplantation and Dialysis: 5 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Speaker: Albert L. Rubin, MD, Professor of Biochemistry and Surgery, The New York Hospital-Cornell Medical Center.

MARCH 18-20, 1970
THE AMERICAN FERTILITY SOCIETY

3rd Postgraduate Course and Annual Scientific Meeting: Washington-Hilton Hotel, Washington, D.C. The postgraduate course offers eight seminars with internationally known moderators. Fee for course (including meals): $75; fee for Annual Meeting: $20. Contact: The American Fertility Society, Herbert H. Thomas, MD, Secretary, 944 South 18th Street, Birmingham, Alabama 35205.

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Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported, in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium and BUN during therapy, particularly in patients with suspected or confirmed renal or hepatic insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—their combined use can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk; thus adverse reactions which have occurred in adults may occur in the fetus or newborn infant. Rarely, thrombocytopenia or pancreatitis has developed in newborn infants whose mothers had received thiazides during pregnancy. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte determinations. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Adjust dose of antihypertensive agents given concomitantly.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, altered carbohydrate metabolism, hyperbilirubinemia, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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executive secretary's newsletter

February, 1970

DEADLINE FOR ANNUAL MEETING RESOLUTIONS

The deadline for receiving resolutions to be considered by the House of Delegates at the Faculty's Annual Meeting is

FRIDAY, FEBRUARY 6, 1970

REFERENCE COMMITTEE MEETING

The Reference Committee, which will evaluate and hear comments on all resolutions introduced for consideration by the House of Delegates, will hold its meeting on Thursday, February 26, 1970 at 8:00 PM, in the Faculty building.

All interested parties are invited to attend and express their views.

SHEEN AWARD

Individuals are invited to submit names to the American Medical Association for consideration for the Sheen Award. The cut-off date is March 15, 1970.

The award, a $10,000 cash gift, is given annually through the AMA for recognition of outstanding contributions to medicine.

MEDICAID CLARIFICATIONS

Information has been received that the Medicaid program authorizes the dispensing of disposable syringes and needles, when prescribed by a physician on Form MS-6.

MEDICAID FORM REVISIONS

The State Department of Health and Mental Hygiene is currently revising the MS-4, MS-6, and MS-9 forms (all forms used by physicians for Medicaid patients).

Those physicians who are vitally interested in suggesting changes or modifications in the forms should contact the Faculty office so that the information can be transferred to the appropriate parties in the Department.

CHARTER TRIPS

There are still several openings for the Faculty's trip to the Orient, leaving Baltimore on May 1, 1970.

CHARTER TRIPS (cont'd)

For further information, call Mrs. Beverly Wolins at Travel Guide Agency - 727-1696.

Dates for the regular fall European trip have been tentatively scheduled for September 10-18. Further details will be available at a later date.

FIRST ISSUE OF THE ASSEMBLYMAN

The first issue of The Assemblyman, containing full details on the 1970 General Assembly session, is in the mail. Look for this important information.

PUBLIC SPEAKING COURSE

A seminar for Public Speakers will be sponsored by the Faculty and the American Medical Association on Wednesday, April 22, 1970 at the Faculty Building. The all-day session is free except for luncheon costs. Preregistration forms will be mailed in February.

The program will include audio visual tape equipment for instant replays for the evaluation of the participants' performances.

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Most states are experiencing sharp rises in professional liability insurance premiums--Maryland is no exception. Bureau rates indicate that in Class V, rates for such insurance ($100,000/$300,000) are $725. Under the Faculty-sponsored program the rate is $479. This reflects a financial saving to the physician of over $245.

While comparable savings are not quite as high in other classes, there are lower premiums..... ALL A BENEFIT OF YOUR FACULTY'S ACTIVITY.

PEER REVIEW AND UTILIZATION REVIEW

The Faculty is currently organizing a special committee to consider Peer and Utilization Review. Its initial discussions will be devoted primarily to review of Medicare and Medicaid activity. It is conceivable that the committee's scope will be expanded to include other related areas needing review.

Any persons interested in participating should advise the Faculty President or the Faculty Staff.

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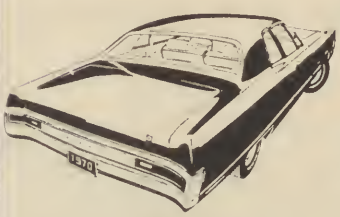
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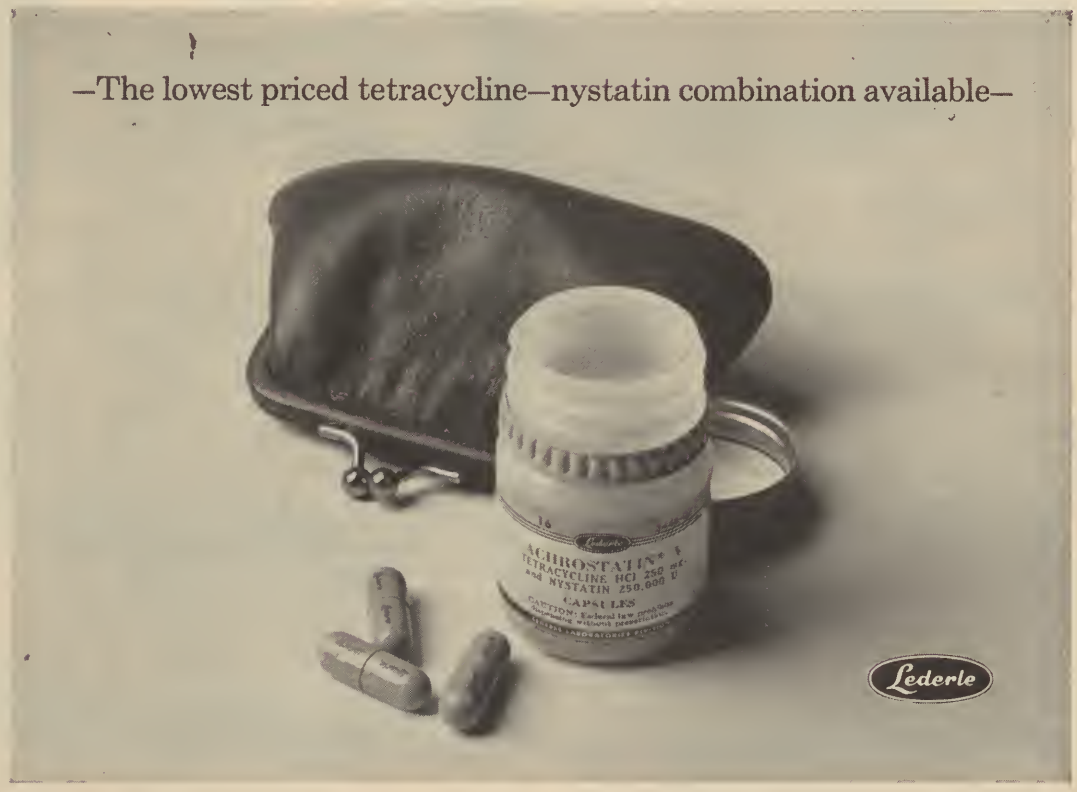
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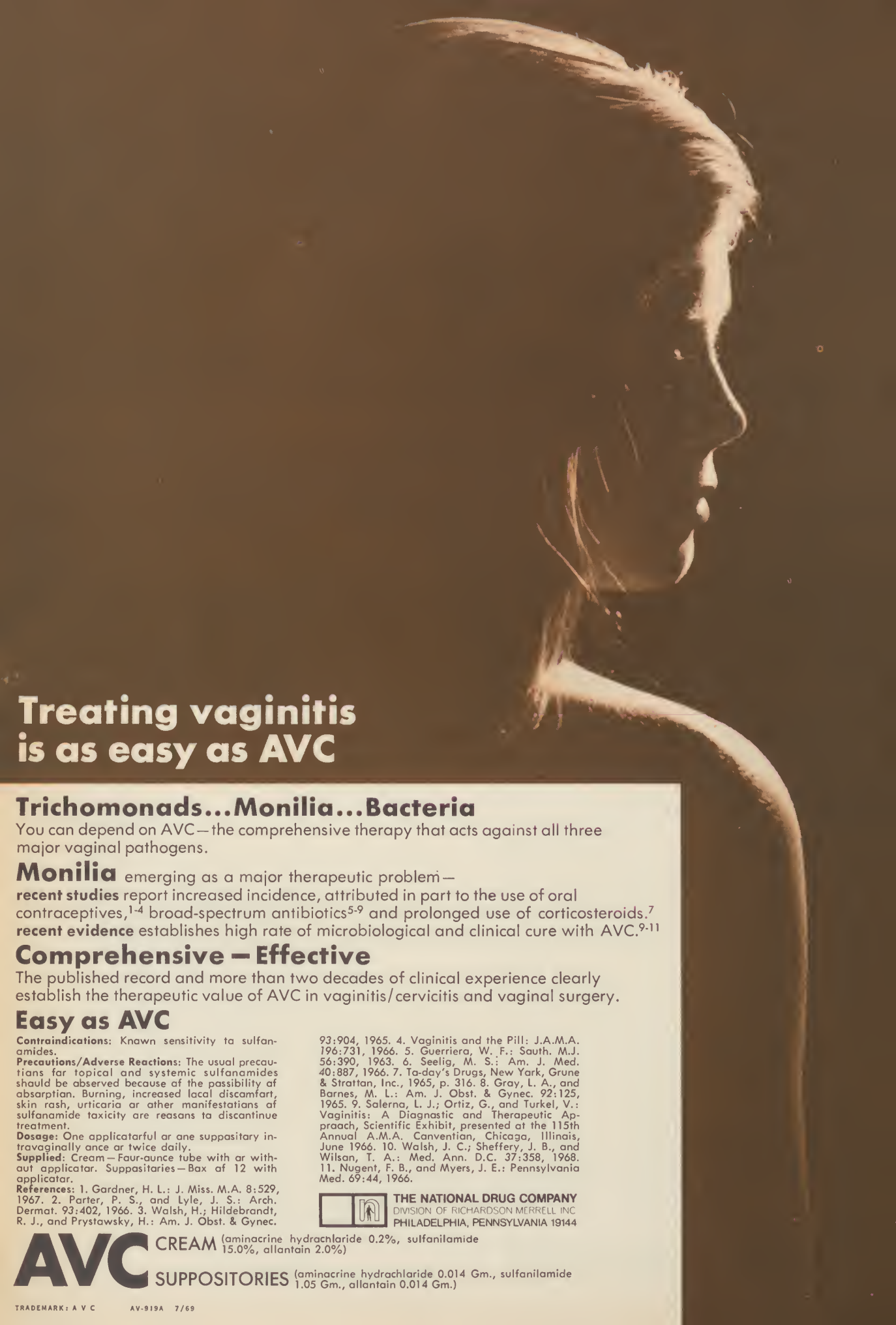
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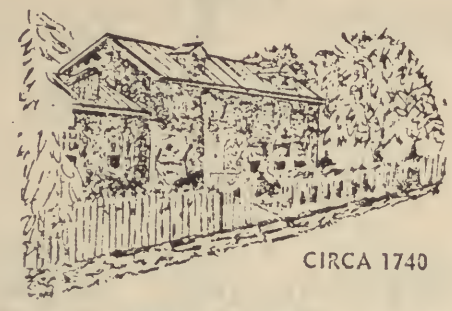
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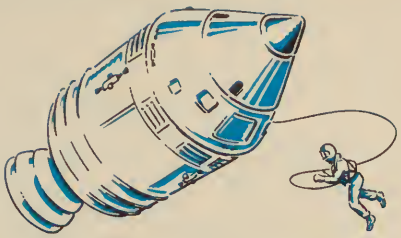
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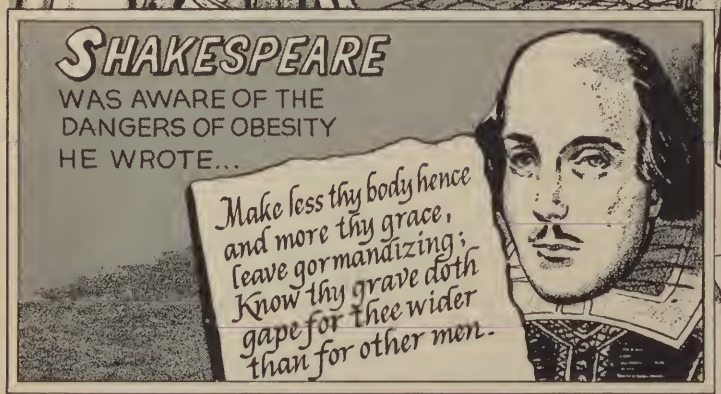
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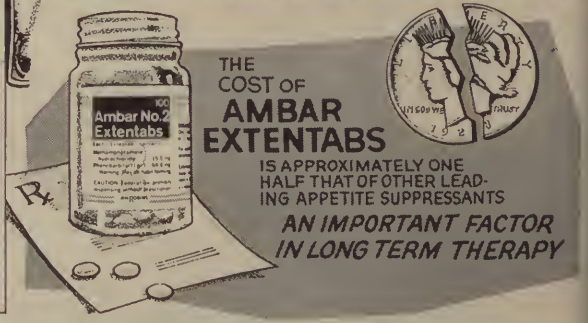


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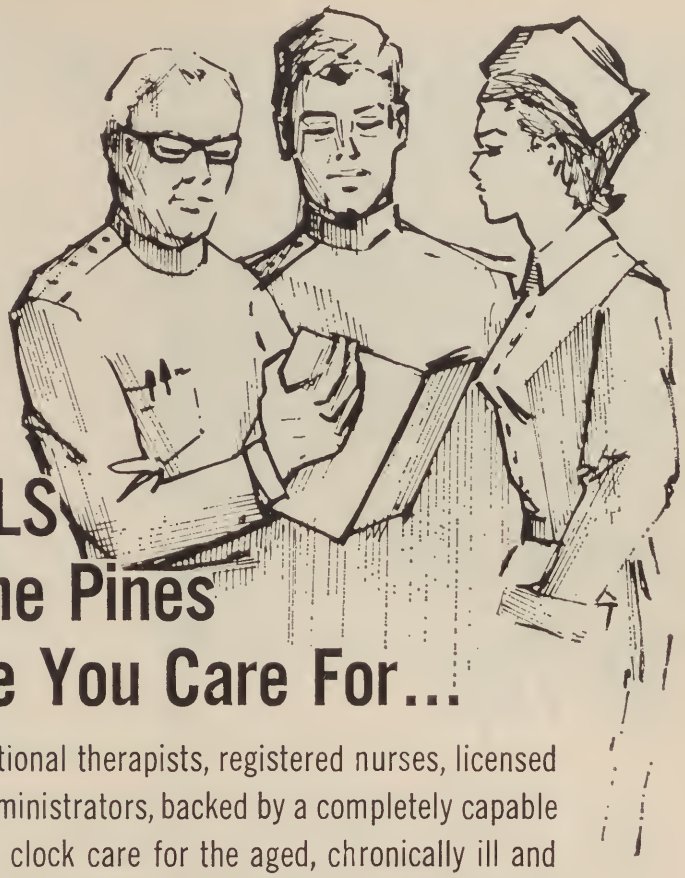


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Replays:	Monday, March 2, 1970	12:30 PM
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MARCH 6, 1970 — 12:30 PM

THE DEPRESSED PATIENT

Frank Ayd, Jr., MD
Diplomate in Psychiatry
Baltimore, Maryland

Of all the ills to which man is heir, depression occurs with the greatest frequency. The object of this presentation is to give the cardinal symptoms of endogenous melancholia and to review various methods of managing patients with this illness. Special attention is given to the art of using chemical remedies for melancholia.

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Replays:	Monday, March 9, 1970	12:30 PM
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MARCH 13, 1970 — 12:30 PM

INDICATIONS FOR TRACHEOSTOMY IN MEDICAL PATIENTS

Douglas G. Carroll, MD
Chief of Physical Medicine and Rehabilitation
Baltimore City Hospitals

Tracheostomy is being used increasingly in hospitalized medical patients for short term treatment of ventilatory insufficiencies and inability to clear secretions adequately. The indications and complications of tracheostomy will be discussed, based on experience at the Baltimore City Hospitals.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, March 16, 1970	12:30 PM
	Wednesday, March 18, 1970	9:00 AM
		2:00 PM

MARCH 20, 1970 — 12:30 PM

COIN LESION IN THE CHEST

Jack Love, MD
Chief of Thoracic and Cardiovascular Surgery
Baltimore City Hospitals

John R. Wright, MD
Assistant Chief of Pathology
Baltimore City Hospitals

In this discussion, a patient with a pulmonary coin lesion will be presented. The management and differential diagnosis of such a patient will be the center of concentration.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, March 23, 1970	12:30 PM
	Wednesday, March 25, 1970	9:00 AM
		2:00 PM

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

February 24	March 24
April 28	May 26

POSTGRADUATE PROGRAMS presented through Medical Education's Dedicated Instructional Channel

Supported in part by a grant from Merck Sharp and Dohme

(See page 30 for a list of participating hospitals and the standard weekly program schedule)

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Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm ... large rock ... tially capsized. The fire depar... had to rescue Waters by smal... Damage to the yacht is estim...

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

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Make your reservations NOW: For information and reservations contact Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles Street, Baltimore 21201 (301-727-0680) or Mrs. Genevieve Ritchie, the Faculty office, 1211 Cathedral Street, Baltimore 21201 (301-539-0872).

(Continued from page 27)



MEDIC 1969-1970 STANDARD WEEKLY PROGRAM SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8						PEDIATRIC GRAND ROUNDS J.H.H.
9			LECTURE REPLAY			
AM 10						
11						MEDICAL GRAND ROUNDS J.H.H.
11:30		MEDICAL GRAND ROUNDS U. OF M.				
NOON 12			C.P.C. J.H.H.			
12:30	LECTURE REPLAY				MEDIC LECTURE	
1						
1:30						
2			LECTURE REPLAY			
3						
PM 4						
5						
6						
7						
8						
9						

OTHER SPONSORS:

Medical and Chirurgical Faculty of the State of Maryland
State Department of Health
Hospital Council of Maryland

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Physicians Memorial, LaPlata
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

Other locations:

Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
(301) 539-0872

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201, (301) 383-3010 Ext. 8722

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THE EXTINCT MEDICAL SCHOOLS OF BALTIMORE, MARYLAND, Harold J. Abrahams, with a foreword by George W. Corner; Maryland Historical Society, 1969.

Judging by the number of inquiries received by the Faculty in the course of a year, this book will fill a definite void for the many genealogists seeking data or information about their forefathers, individuals seeking information as to when and where a relative or friend graduated from medical school, and other interested parties who have been requesting such data from this book for some time.

The title of this book could well be "The Extinct Medical Schools of Maryland", for there were none elsewhere in the state. Strange names such as The Medico-Chirurgical, and Theological College of Christ's Institution appear in the book—a school which was chartered in 1910 but never came into existence. A second phantom school was the Maryland College of Eclectic Medicine and Surgery, organized in 1912, which bore three different names in as many years. These institutions were reminiscent of the diploma mills castigated in the now famous Flexner report.

This book is well written, although the photo offset process makes it somewhat difficult to read. It is complete, even to a listing of the teachers at these schools, as well as a listing of individuals who did and did not graduate from these courses. It provides a means for historical research and is a book that will add greatly to the value of medical and other libraries devoted to research and history.

CURRENT CONCEPTS IN OPHTHALMOLOGY, VOLUME II, Bernard Becker, MD, and Ronald M. Burde, MD; The C. V. Mosby Company, St. Louis, Mo. 1969.

The aim of this volume, the second having been prompted by the enthusiastic response to the first, is to bring the reader current thoughts and practices in this particular field of medicine.

Topics have been selected that need clarification in the light of present-day knowledge. It does this well, and those who found the first issue stimulating will, no doubt, find the second one more so.

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THE MONTH IN WASHINGTON



The Internal Revenue Service postponed until January 1, 1971 one provision of a new requirement that health insurance companies report to the IRS payments of $600 or more a year to a physician.

The delayed provision covers payments for services not covered by medicare and medicaid. Payments of $600 or more under these government programs *must* be reported to the IRS. A spokesman said the reporting of payments was delayed for a year to allow further time for working out compliance procedures.

The IRS regulation applies only to direct payments to physicians. The Senate added an amendment to an omnibus tax bill that would have extended the requirement to indirect payments also. But House-Senate conferees took out the amendment.

Another provision unfavorable to physicians was knocked out of the tax bill, but a third was retained.

The Senate rejected a proposal that would have restricted the tax advantages gained by physicians who organize professional corporations under state laws to establish retirement plans. The Senate Finance Committee had added an amendment that would have set an annual limit of $2,500 per individual, the same as specified under the so-called Keogh law. But the Senate, by a vote of 65 to 25, knocked out the amendment, leaving physicians, lawyers, engineers and other members of professional corporations able to set aside as much of their income for retirement as they choose.

As finally passed by Congress, the measure includes a provision putting congressional approval on an IRS ruling that advertising revenue of medical and other nonprofit, tax-exempt organizations is subject to the regular corporate income tax. Journals of state medical societies, as well as the *Journal of the American Medical Association,* are affected.

* * *

Medicare's Part B premium partially covering physicians' fees will go up from $4 to $5.30 a month next July 1.

Health, Education and Welfare Secretary Robert H. Finch blamed his predecessor in the post, Wilbur J. Cohen, for the size of the 32% increase in the premium which is matched by the federal government.

Finch noted that the present $4 premium rate, set in December 1968, was too low to cover costs during the current premium period and that the special Medical Insurance Trust Fund has been drawing on its reserves. He said that failure to increase the premium rate last December, in accordance with advice from Social Security Administration actuaries had made it necessary now, in effect, to promulgate two increases at once. Moreover, the depletion of the trust fund that has occurred because of the inadequate rate has made it necessary, he said, to provide for a somewhat higher margin of contingency than would otherwise be necessary.

About half the increase, 64 cents, was needed to finance the program at the level of current operations. The other 66 cents of the $1.30 increase was distributed as follows:

- 26 cents to cover an estimated increase of about 6% in the level of physicians' fees;
- about 12 cents to cover an estimated increase of 2% in the utilization of services under the program;
- about 6 cents because the $50 deductible which a patient pays will be a smaller proportion of the total covered charges;
- the remaining 22 cents to provide a 4% margin for contingencies.

* * *

President Nixon signed into law legislation setting tough federal safety standards for coal mines.

Although he had reservations about a conflict with state workmen's compensation laws, Nixon said "the health and safety provisions of this act represent an historic advance in industrial practices." He also cautioned that this law should in no way "be considered a precedent for future federal administration of workmen's compensation programs."

The Secretary of HEW was given authority, for the first time, to set health standards for mines. Nixon said he had asked that wherever possible the disability standards under the new act be consistent with those of the Social Security disability program.

Pressure for the legislation started building up after 78 died in a Mannington, W. Va. mine disaster last November.

The AMA supported an overall Administration bill on occupational health and safety, and pledged the backing of the nation's physicians for any program "well designed to improve the safety and health of the American worker."

R. Lomax Wells, MD, Silver Spring, immediate past chairman

of the AMA's Council on Occupational Health, told a Senate labor subcommittee:

". . . the American Medical Association supports the new Administration bill, S. 2788. Its provisions for standard setting, not in the Labor Department but in a new National Occupational Safety and Health Board appointed by the President, with a majority of professional experts, seems to us an acceptable equivalent to our previous suggestion of a National Council on Hazardous Physical and Chemical Agents. We endorse its concept of a separation of powers between standard setting and enforcement. We welcome, in this new bill, the intent to give a larger role to the Department of Health, Education and Welfare, whose competence in this field is recognized. Our Association approves the provision for federal support of state occupational safety and health programs to supplement inadequate manpower in the federal system. We believe that this emphasis on support of the state programs, combined with standard setting by an independent professional board, is greatly preferable to mandatory national standards promulgated and enforced by a single federal agency. In this regard, we welcome the stress on the use of consensus standards, and provisions for consultation with professional standard-setting agencies before establishing needed new standards."

* * *

A National Heart and Lung Institute task force predicted that the demand for heart transplants will increase beyond the present level of about 100 a year and exceed the number of the organs available for the operation.

The report of the task force on cardiac replacement also said:

● Less than 16% of the 200,000 Americans under 65 who die each year from heart disease are good candidates for transplants. ● Rejection of the transplanted heart will remain "the greatest barrier to prolonged survival." ● Development of an artificial heart is now a distinct possibility. ● The federal government should emphasize research on the prevention, early detection and early treatment of heart disease. ● A new definition of death is needed. ● Total transplant charges for 36 patients averaged $18,694 per patient. ● Heart transplants have been performed on 148 patients, with 23 persons still surviving, 16 of them in the United States. ● More than 32,000 heart disease victims can be considered transplant candidates, but there are only about 22,000 possible donors a year, the report said.

* * *

The Food and Drug Administration was reorganized and given independent status under a new commissioner.

The reorganization followed several years of criticism of the Health, Education and Welfare Department agency from all sides —Congress, industry and consumers' groups. The criticism resulted in a two-month study by a task force headed by HEW Deputy Assistant Secretary for Welfare Fred Malek.

The reorganization focused on FDA's structural problems and the chief aim of HEW Secretary Robert H. Finch appeared to be to get the agency operating more efficiently. FDA was taken out of the Consumer Protection and Environmental Health Service and placed in the department's staff structure on an equal basis with the remaining Environmental Health Service and the National Institutes of Health.

Charles C. Edwards, MD, formerly a division director on the American Medical Association headquarters staff, was named to replace Herbert L. Ley, Jr., MD, as head of the FDA. Ley was offered another post in HEW but declined it. Two of Ley's top aides, FDA Deputy Commissioner Winton B. Rankin and Associate Commissioner for Compliance J. Kenneth Kirk, were transferred from the agency.

Edwards was praised by a former associate on the AMA staff, C. Joseph Stetler, president of the Pharmaceutical Association, as being highly qualified by his scientific and administrative background.

The new FDA head said he would bring "hard-nosed management principles" to the agency and work more closely with industry, but that his administration of FDA would be oriented to the consumer. He said his decisions as a government official will not be influenced by his former association with the AMA.

* * *

"AMA Registry on Adverse Reactions" Needs Information from Hospitals

The editors of the *AMA Registry on Adverse Reactions Due to Occupational Exposures* need the assistance of hospital medical staffs in collecting information on adverse effects resulting from new chemicals, biological or physical agents, or from exposure to old materials used in new processes. The *Registry* hopes to delineate newly recognized occupational disease manifestations.

Physicians are urged to submit reports of single observations, from which the aggregate compilation may establish the probability of a causal relationship between a special exposure and an adverse effect.

Report forms are available from the AMA Department of Occupational Health, 535 North Dearborn Street, Chicago, Ill. 60610.

Venereal Disease Treatment Schedule

Maryland State Department of Health
Division of Communicable Diseases
Venereal Disease Control Section
11/3/69

Diagnosis	Treatment	Comments and Follow-Up
1. Primary Syphilis 2. Secondary Syphilis	2,400,000 units of Benzathine Penicillin G (Bicillin) IM at a single session (1,200,000 units in each buttock)	STS in 30 days then every 3 months for a year.
3. Late Syphilis		
A. *Early Latent Syphilis* (Less than 2 year's duration)		
1. Nonreactive Spinal Fluid Examination	2,400,000 units Bicillin IM at a single session (1,200,000 units in each buttock)	STS every 3 months for 1 year; then every 6 months for a year—for a total of 2 years.
2. No Spinal Fluid Examination Done	7,200,000 units Bicillin IM total (2,400,000 units weekly × 3)	Same as above
B. *Late Latent Syphilis* (more than 2 year's duration)		
1. Nonreactive Spinal Fluid Examination	2,400,000 units Bicillin IM at a single session (1,200,000 units in each buttock)	STS every 3 months for 1 year; then every 6 months for a year—for a total of 2 years.
2. No Spinal Fluid Examination Done	7,200,000 units Bicillin IM total (2,400,000 units weekly × 3)	Same as above
C. Late Manifest Syphilis Cardiovascular Neurosyphilis Other	7,200,000 units Bicillin IM total (2,400,000 units weekly × 3)	STS every 3 months for 1 year; then every 6 months for a year—for a total of 2 years. In neurosyphilis, the spinal fluid should be re-examined 6 months after treatment.
4. Congenital		
A. Early (Patient under 2 years old)	50,000 units Bicillin per kg. body weight in a single dose.	STS every 3 months for 1 year
B. Late (Patient over 2 years old)		
1. under 12 years; weight 70 lbs. or less	1,200,000 units Bicillin IM in a single injection	STS every 3 months for 1 year; then every 6 months for a year
2. 12 years or older but weight more than 70 lbs.	same as stage of late syphilis	same as stage of late syphilis
5. Syphilis in Pregnancy	According to Stage	According to Stage
6. Prophylactic Treatment for Syphilis	2,400,000 units of Bicillin IM at a single session	STS monthly for 3 months
7. Gonorrhea in Males	2,400,000 units of Aqueous Procaine Penicillin IM at a single session	STS at time of treatment. Repeat in 4 months if non-reactive. Culture at time of treatment and 4 to 7 days after treatment.
8. Gonorrhea in Females	4,800,000 units of Aqueous Procaine Penicillin IM at a single session (2,400,000 units in each buttock)	STS at time of treatment. Repeat in 4 months if non-reactive. Culture at time of treatment and 4 to 7 days after treatment.
9. Prophylactic Treatment for Gonorrhea	same as above for each sex	same as above for each sex
Alternate Antibiotics (for those sensitive to Penicillin)		
Gonorrhea	Tetracycline or Erythromycin 1.5 gm orally; then 0.5 gm orally 4 times a day for 4 days (9.5 gm) (Same for prophylactic treatment of contacts)	
Syphilis		
1. A. Primary and Secondary B. Latent cases with nonreactive spinal fluid examination	Tetracycline *or* Erythromycin 0.5 gm orally 4 times a day for 15 days (30 gm) (Same for prophylactic treatment of contacts)	
2. A. Late Manifest B. Latent cases with no spinal fluid examination done	Tetracycline *or* Erythromycin 0.5 gm orally 4 times a day for 30 days (60 gm)	
Note: Erythromycin is the preferred alternate antibiotic for pregnant patients.		
10. Chancroid	Sulfonamides such as Sulfadiazine 1.0 gm qid for 7 days or Tetracycline 0.5 gm orally qid for 14 days	STS at time of treatment, then monthly for 3 months
11. Granuloma Inguinale	Tetracycline orally 0.5 gm qid for 15 days	STS at time of treatment. Repeat in 4 months if nonreactive.
12. Lymphogranuloma Venereum	Tetracycline orally 0.5 gm qid for 10 days	STS at time of treatment. Repeat in 4 months if nonreactive.

ANNUAL MEETING PROGRAM

Wednesday, April 1, 1970

The Alcazar, Baltimore

9:30 AM—Meeting of the House of Delegates

2:00-4:30 PM—Scientific Session

Doctor-Patient Relationship and Management of the Neurotic Patient
Roy W. Menninger, MD, President, The Menninger Foundation, Topeka, Kansas

The Future of Medical Education: Undergraduate and Postgraduate
George James, MD, Dean, Mount Sinai School of Medicine, New York

The Emerging Physician's Assistant
Hu C. Myers, MD, Medical Director, Chief of Surgery, Director of Cancer Clinic, Broaddus Hospital, Philippi, West Virginia

The Belvedere Hotel, Baltimore

5:30-7:00 PM—Hospitality Night for all members of the Faculty and their wives

7:00 PM—International Dinner and Entertainment sponsored by the Woman's Auxiliary

Thursday, April 2, 1970

The Alcazar, Baltimore

9:30 AM-Noon—Scientific Session

Medical Grand Rounds
A. McGehee Harvey, MD, and Medical Staff of The Johns Hopkins University School of Medicine

Diagnostic Limitations of Body Fluid Enzyme Alterations: A Reappraisal
Felix Wroblewski, MD, Associate Professor of Clinical Medicine, Cornell University Medical College, New York

Noon—Election of Board of Medical Examiners

The Belvedere Hotel, Baltimore

12:30 PM—Annual Round Table Luncheon, which will include meetings of the alumni associations of several medical schools, as well as the usual scientific subjects

The Alcazar, Baltimore

2:15-4:45 PM—Scientific Session

Surgical Grand Rounds
Robert W. Buxton, MD, and Surgical Staff of the University of Maryland School of Medicine

Venous Bypass Grafting for Coronary Artery Disease
Frank C. Spencer, MD, Professor and Chairman, Department of Surgery, New York University Medical Center

The Blue Crest North, Baltimore

6:15 PM—Annual Presidential Reception and Banquet in a delightful atmosphere with delectable cuisine, hors d'oeuvres, cocktails and dancing for all to the music of Rivers Chambers' Orchestra

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

Friday, April 3, 1970

The Alcazar, Baltimore

9:15 AM-12:30 PM—Scientific Session

The Eye in Systemic Disease
Daniel M. Gordon, MD, Associate Professor of Ophthalmology, Cornell University Medical College, New York

The Harmful Use of Sex
John Rock, MD, Clinical Professor Emeritus of Gynecology, Harvard Medical School

Pulmonary Embolism: Its Causes and Prevention
William H. Moretz, MD, Chairman, Department of Surgery, Medical College of Georgia

Physical Examination of the Joints: A Challenge
William P. Beetham, Jr., MD, Lahey Clinic Foundation, Boston

Osler Hall, Faculty Building, Baltimore

2:00 PM—Meeting of the House of Delegates

* * * * * * *

HEALTH EVALUATION TESTS—The Alcazar

This ever popular benefit of membership in the Medical Faculty will again be available for physicians at the Alcazar during the Annual Meeting

* * * * * * *

ARTS AND HOBBY EXHIBIT—The Alcazar

An opportunity is offered for physicians, their wives, and families to put their artistic talents on display *(see page 66 for the application form).*

* * * * * * *

SCIENTIFIC AND TECHNICAL EXHIBITS AT THE ALCAZAR

Wednesday, Thursday, and Friday
Intermissions will be provided to visit these exhibits
which constitute a symposium on therapeutic progress.

(See page 40 for a list of Technical Exhibitors to date)

PLAN TO ATTEND
MARK THESE DATES ON YOUR CALENDAR

APRIL 1, 2, 3, 1970

172nd ANNUAL MEETING

Prominent speakers* who will present papers during the Annual Meeting in April include **John Rock, MD, Hu C. Myers, MD, and Frank C. Spencer, MD.**

The Harmful Use of Sex will be the title of the Hundley Memorial Lecture in Gynecology to be given by **John Rock, MD,** on Friday, April 3, at the Alcazar. Dr. Rock, Clinical Professor of Gynecology, Emeritus, Harvard Medical School, was graduated from Harvard College and received his MD degree from Harvard Medical School. In the 1920's he began the practice of obstetrics and gynecology in Boston and started a Fertility Clinic at the Free Hospital for Women in Brookline, Massachusetts. From the beginning, his professional activities have been concerned mainly with the needs of couples who are involuntarily childless, and his research has concentrated on the first stages of conception, the development of the human embryo, and the clinical disorders of human reproductive physiology.



Dr. Rock

Dr. Rock served as Clinical Professor of Gynecology at Harvard from 1947 until his retirement in 1956. In 1956 he established the Rock Reproductive Clinic, Inc., in Brookline. He is the recipient of the Lasker Award of the Planned Parenthood Federation of America, the Ortho Award of the American Gynecological Society, and the Ortho Award of the American Society for the Study of Sterility. He holds honorary degrees from the University of San Marcos in Lima, Peru, the University of Chile in Santiago, Chile, Amherst College, and Harvard University.

Dr. Rock is co-author of *Voluntary Parenthood.* His most recent book, *The Time Has Come, A Catholic Doctor's Proposals to End the Battle Over Birth Control,* was published in 1963 and has been translated into four foreign languages.

The annual I. Ridgeway Trimble Fund Lecture will be given by **Frank C. Spencer, MD,** Professor and Chairman, Department of Surgery, School of Medicine, New York University. The subject Dr. Spencer will discuss is *Venous Bypass Grafting for Coronary Artery Disease.* Dr. Spencer was graduated Magna Cum Laude from the North Texas State University and received his MD degree from Vanderbilt University School of Medicine in 1947 receiving at that time the Founder's Medal Scholarship Award. After serving an internship and fellowship in surgery at The Johns Hopkins Hospital, he went to Wadsworth Hospital in Los Angeles as an assistant resident surgeon. Following this he was a fellow in cardiovascular surgery at the U. S. Public Health Service, UCLA School of Medicine. From 1951 to 1953, Dr. Spencer was in the Medical Corps of the U.S. Navy.



Dr. Spencer

In 1954, Dr. Spencer came back to Hopkins as an instructor in surgery, where he continued as resident surgeon, assistant professor of surgery, associate professor of surgery, and surgeon-in-charge of the Emergency Department, until 1961. From 1957 to 1965 he served as a consultant in surgery at the Walter Reed Army Hospital, the National Heart Institute, and the Veterans Administration Hospital (Lexington, Kentucky). Dr. Spencer was professor of surgery at the University of Kentucky School of Medicine from 1961 to 1965. In January 1966 he became affiliated with the Department of Surgery, School of Medicine, New York University, as professor and chairman. He is also director of New York University, Surgical Divisions, Bellevue Hospital; and director of surgery at

* See the January Journal for capsule biographies of **Roy W. Menninger, MD, George James, MD, Daniel M. Gordon, MD** and **William H. Moretz, MD.**

SPEAKERS – APRIL 1, 2, 3

University Hospital in New York City.

Dr. Spencer is a member of fifteen medical associations, including the American College of Surgeons, Society of Clinical Surgeons, and Society for Vascular Surgery. He is certified by the American Board of Surgery and the Board of Thoracic Surgery. The many honors bestowed upon him include the Alpha Omega Alpha at Vanderbilt; the Legion of Merit Award, U.S. Navy; Annual Research Award, University of Kentucky Alumni Association; and the Faculty Achievement Award, Kentucky State Medical Association.

Hu C. Myers, MD, will give the Harvey Grant Beck Memorial Lecture on *The Emerging Physician's Assistant*. This has been scheduled for Wednesday afternoon, April 1, at the Alcazar. Dr. Myers was a member of the Advisory Council on the Physician's Assistant Program of Alderson-Broaddus College, which recently established a course with a Bachelor of Science degree for the Physician's Assistant. The purpose of the curriculum is to create learning experiences designed to prepare selected students to perform for patients physician-directed, supervised, and identified personal medical services at levels of competence acceptable to the medical profession. The supervising physicians, through the Assistant, may be freed to devote their personal efforts to the more critical and demanding problems which face their patients.



Dr. Myers

Chief of Surgery at Broaddus Hospital in Philippi, West Virginia, Dr. Myers is also Professor of Medical Science and Director of the Physician's Assistant Program at Alderson-Broaddus College. Dr. Myers received his MD degree from Emory University and served an internship at the Steiner Cancer Clinic of Grady Hospital, and a residency at the Georgia Baptist Hospital. He is a Diplomate of the American Board of Surgery, and a fellow of both the American College of Surgeons and the Southeastern Surgical Congress. Dr. Myers is a past president of the Tygart's Valley Medical Society, West Virginia Division of the American Cancer Society, and the West Virginia Hospital Association. He is currently president of the West Virginia State Board of Health, and president of the Board of the Cancer Clinic at Broaddus Hospital.

Dr. Myers is the recipient of the following awards: Gold Medal, Southeastern Surgical Congress; Citizen Award, West Virginia Public Health Association; ScD (honorary) degree, Alderson-Broaddus College; Medical Records Award, American College of Surgeons; and Distinguished Service Award, American Cancer Society. He is the author of forty published papers on a variety of surgical subjects and has developed scientific exhibits on cancer, cyanoacrylates in surgery, new surgical instruments, and various research projects.

See the March Journal for capsule biographies of other speakers including:

Felix Wroblewski, MD,
Associate Professor of Clinical Medicine,
Cornell University Medical College, New York

and

William P. Beetham, Jr., MD,
Lahey Clinic Foundation, Boston

THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM

of the

MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING

at the Alcazar

APRIL 1, 2, 3, 1970

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(as of January 15, 1970)

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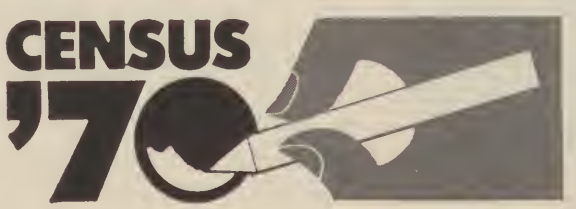
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Joint Anesthesia Study Committee—

Calbert T. Seebert, MD, Chairman
Joint Anesthesia Study Committee

"On April 26, 1953, the president of the Baltimore City Medical Society, after conferring with the Commissioner of Health of the City of Baltimore, appointed a committee for the purpose of studying the causes of death and sequelae during and following surgical and obstetrical procedures in the City of Baltimore." [1] This Committee is now known as the Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department. Otto C. Phillips, MD, was the first Chairman of the Committee. Mr. Todd M. Frazier, formerly Director of the Bureau of Biostatistics in the Baltimore City Health Department, was also instrumental in the organization of the committee.

"The objective of this committee, as adopted at its first meeting held on May 25, 1953, is to discuss every death in this city that occurs the day of, or the day after the operation, for the purpose of uncovering repetitive errors and for the dissemination of information on errors, with no attempt by the committee, in any case, to identify any individual or hospital." [1] With the present-day revision of the definition of death by Denton Cooley, MD, the Committee has also decided to review all cases in which there is major brain damage within 48 hours of the induction of anesthesia.

Collection of Cases

The first step in the collection of cases for the Joint Anesthesia Study Committee is made by the Baltimore City Health Department, which obtains the necessary information from the death certificate. An identification number is assigned to each death certificate, and these are then kept in a separate file at the Health Department. An explanatory letter is forwarded to the Department of Anesthesiology of the hospital concerned, along with an outline for a case study and an envelope addressed to the Committee Chairman in care of the Medical Society.

Upon receipt of the completed case protocol by the chairman, the only identifying information on the form is the case number assigned. The case protocols, when returned, are then reviewed by the chairman or by a Screening Committee composed of the other members of the Joint Anesthesia Study Committee. All cases are disposed of in which there is unanimous agreement by the committee members that anesthesia had no plausible role in the eventual outcome. In cases in which the anesthetic management contributed to the patient's death, the error in the phase of anesthetic management is further described. All of the collected information is then tabulated on a code sheet by the chairman.

The code sheets are then sent to the Bureau of Biostatistics of the Baltimore City Health Department. Some of the items which are coded include information on the patient's age, sex, race, preoperative condition, preoperative and postoperative diagnosis, operation proposed and performed, primary anesthetic agent and technique, relaxants, technique for maintaining the airway, postoperative condition, and the vote of the Anesthesia Study Committee. Miss Elizabeth Kelly, present Director of the Bureau of Biostatistics in the Baltimore City Health Department, is in charge of transferring the information to punch cards and the tabulations required for the statistical analysis of the case material.

Organization and Function

Open Committee Meetings

Seven or eight discussion meetings are held at the auditorium of the Medical and Chirurgical Faculty during the academic year. The meetings are always on the fourth Tuesday of the month at 7:30 PM. Notices of the meeting are mailed to the anesthesia departments of all hospitals in the State of Maryland, with the exception of those in the District of Columbia suburbs. All physicians and nurse anesthetists are invited to attend. Two interesting teaching cases are presented at each meeting. Case protocols are summarized in advance of the meeting and forwarded to the speakers and other interested physicians in the state. Additional copies are distributed to the audience at the time of the meeting. Leaders in the fields of anesthesiology, medicine, and surgery from the city present the case reports and lead the discussion which follows. The meeting is informal and the audience enters freely into the discussion and the question and answer period at the end of each case presentation.

Because of the declining attendance at the open committee meetings during the past academic year, the chairman decided to invite outstanding out-of-town physicians to participate in several of the meetings. On September 24, 1969, Robert D. Dripps, MD, Professor and Chairman of the Department of Anesthesiology at the University of Pennsylvania, spoke on "The Anesthetic Management of the Pulmonary Cripple" and presented two illustrative cases from the files of the committee. On November 25, 1969, John Adriani, MD, Director of Anesthesiology at Charity Hospital in New Orleans, Professor of Surgery (Anesthesiology) at Tulane University School of Medicine and Clinical Professor of Pharmacology and Surgery at the Louisiana State University School of Medicine, spoke on the subject of "Neuroleptanalgesia" and presented illustrative cases from our files. Jay Jacoby, MD, Professor and Chairman of the Department of Anesthesiology at Jefferson Medical College will speak to the organization on April 28, 1970.

The chairman feels that bringing nationally prominent anesthesiologists to Baltimore will create added interest in the work of the committee and provide more interesting and fruitful meetings.

During the academic year 1968-1969, 348 requests for case studies were sent from the Bureau of Biostatistics to 17 hospitals in Baltimore city. Adequate case reports were returned in 187 instances. The anesthetic management was found to have contributed to the death of the patient in 12 cases. In three cases, errors in anesthetic management were the primary cause of death. In nine cases, errors in anesthetic management were one of several contributing factors in the patients' deaths.

The failure of the anesthesiologists in the city to return more of the requested case reports has limited the function of the committee as a retriever of medical information. However, the monthly open committee meetings, particularly with out-of-town guest speakers, continue to serve as an excellent teaching tool in the continuing education of the practicing anesthesiologist.

REFERENCE

1. Phillips, Otto C. and Frazier, Todd M.: The Baltimore Anesthesia Study Committee Organization and Preliminary Report, *Anesthesiology* **18**:33 (January-February), 1957.

The anesthesiologist as a physician has existed for almost 125 years, but it is only within the last few decades that anesthesia has become recognized as a specialty and its beneficial effects appreciated. The primary change has been in the area of the patient's safety. Knowledge of physiology and pharmacology was joined to the technique and administration of anesthetics, and both have matured into a philosophy of the management of patients under anesthesia.

ANESTHESIA — 1970

MARTIN I. GOLD, MD
President
Maryland-D.C. Society of Anesthesiologists
Professor
Department of Anesthesiology
University of Maryland School of Medicine

The anesthesiologist no longer practices a technical discipline but cares for his patient in three general stages:

1. **The Preoperative State** The primary functions of the anesthesiologist here are to assess the patient's medical and surgical problems, to request consultation, and to call for further laboratory tests in relation to his proposed anesthetic. The anesthesiologist may advise the surgeon to delay elective surgery until the patient's physical condition is improved.

2. **The Anesthetized State** At the present time, the anesthesiologist produces anesthesia which is considered adequate or inadequate based on a clinical evaluation of the patient's condition and needs. For years, complicated signs corresponding to stages and planes of anesthesia were used to follow a patient's course. In many instances, the blood oxygen tension decreased and the carbon dioxide tension increased. A revolution occurred with the advent of muscular relaxation, the need for artificial ventilation, and the realization that a patient's tidal volume should be augmented during anesthesia. Therefore, in addition to preserving normal blood gases, the anesthetist removes consciousness and memory, produces analgesia, raises or lowers blood pressure, decreases neuromuscular activity, and affects acid-base balance, metabolism, and blood volume.

3. **The Immediate Postoperative State** This has been and remains a difficult and trying period for surgical patients. A major advance occurred when the first postanesthetic recovery room was opened. This became the first hospital intensive care area. With the development of more skillful and specialized surgery, ancillary nursing help, improved equipment, and the availability of blood, the physician-anesthetist has allowed the surgeon to become far more daring. Many poor-risk patients survive surgery only to succumb immediately postoperatively, with the primary cause of death termed "respiratory." To a degree, the surgical anesthetic team is guilty of creating a "Frankenstein monster" which would never have lived through anesthesia and surgery a decade or two ago. Instead, operations are "successful" but the patient dies in the immediate postoperative period.

As a specialty, anesthesia has finally been accepted by the medical profession, lay people, the church (years ago, anesthesia was forbidden), deans of medical schools who seek advice from professors of anesthesia (three anesthesiologists are currently deans of medical schools), hospital directors and administrators, and insurance companies (which impose an increasingly more expensive malpractice rate for coverage of anesthesiologists).

One of the primary reasons for surgical success involves a duality of responsibility [1]; the surgeon skillfully repairs and resects, while the anesthesiologist, concerning himself with the administration of reversibly-acting poisons, maintains "normal" cardiovascular and respiratory physiology. The primary goal of both the surgeon and the anesthesiologist is to see that the patient leaves the hospital with a resected or repaired lesion. The primary purpose of the anesthesiologist is to see that life processes, especially the central nervous system, remain basically unchanged.

Shortage of Qualified Anesthesiologists

However, there is an acute shortage of trained, medical anesthesiologists.[2] Graduates of American medical schools have not filled American anesthesia residencies. Foreign graduates have certainly helped fill the vacancies, but a serious shortage still exists. Nurses and inadequately trained physicians have admirably filled in and performed excellently, but until an adequate number of Board-qualified and -certified anesthesiologists are available, and until all obstetrical and even dental anesthesia is performed by qualified anesthesiologists, serious shortage will exist.

Currently, only 59% of anesthesiologists are Board-certified; 14 other specialties have a higher incidence of Board certification while only four have a lower incidence.[3] Anesthesiologists administer approximately 40% of all anesthesia in the United States; nurses with training in anesthesia administer an additional 40%; 20% is evidently administered by general practitioners, dentists, and other personnel with a somewhat inadequate background.[4]

To compound this shortage, an increasing number of duties are performed by anesthesiologists, some of whom actively seek escape from the operating room routine to form a more lasting physician-patient relationship. Some anesthesiologists direct pain block clinics; others join organ transplant and cardiovascular bypass teams; some become heads of inhalation therapy departments; while others supervise and function in acute pulmonary care units. These activities may assume a major portion, if not the entire portion of the physician's medical practice. Therefore, the number of physicians practicing anesthesia may actually decrease.

Since much anesthesia is routine, and because this shortage of physician-anesthesiologists exists, it has been suggested that nurses or "anesthesia technicians" provide the "simple anesthesia" for "simple surgery." While this plan has been partially successful in the past, has practical aspects at present, and certainly merits consideration, the specialty is concerned that such a double-standard may be self-deprecating.[2] To have someone other than a physician-anesthesiologist administer anesthesia, which is the practice of medicine, has no analogy in other specialties, with the possible exception of midwifery in obstetrics. If personnel must continue to be drawn from the allied medical specialties to administer anesthesia, will the

specialty become less aggressive and overly compliant by working hand-in-hand with the nurse-technician?

On the other hand, the nurse anesthetist has done an admirable job, often under extreme duress since the "umbrella" of being a physician is absent in a frequently stormy operating room. There is no doubt that these individuals are skilled, professional, and responsible nurses. In addition, nurse anesthetists have not always received adequate recognition for their professional abilities. It is also a fact that at this time in the U.S. anesthesiologists cannot replace nurse anesthetists, nor will they in the near future.

Presently, only about 15% of obstetrical anesthesia in the United States is given by anesthesiologists. Therefore, 85% of these patients are receiving less than the best we have to offer. In Canada, a Board-certified anesthesiologist is present at approximately 60% of all deliveries.[5] According to a recently conducted survey, when the anesthesia was administered by an anesthesiologist, those babies delivered were in better condition.[6]

General anesthesia is given to many patients each day in the dentist's office under adverse conditions. These patients are operated upon within the site of the airway, frequently by professional and competent individuals extremely skillful in surgical technique but with relatively inadequate training in the administration of anesthesia and the preservation of the airway. The "operator-anesthetist" is to be condemned.[7] It is believed that these patients may be subjected to unknown periods of hypoxemia and hypercarbia. Frequently these patients have received inadequate premedication or none at all, and many have no preanesthetic physical examination or history. Fortunately, many dental surgeons have had excellent training in physical diagnosis and examination, and are able to refer the ill patients to hospitals for adequate diagnostic or therapeutic measures or both. In addition, sitting patients are in an unfavorable circulatory position. The oral surgeon may not be trained in resuscitation techniques or in making a diagnosis should a catastrophe occur. It is doubtful, for instance, that every office in which general anesthesia is administered has an electrocardiograph and a defibrillator.

The Time Factor

Utilization of the anesthesiologist's time through proper scheduling has been, is, and will become an even greater problem in the near future. With anesthesiologists in extremely short supply, it is interesting that in Great Britain, where anaesthetists comprise 3.9% of the medical population, all surgical anesthesia is administered by physicians. In the United States, anesthesiologists comprise 3.6% of the medical population,[5] but they administer only 50% of the anesthesia for surgical cases. Many factors influence this inequality, such as the difference in philosophy of speed by the surgical team.

One area requiring thought by both surgeons and anesthesiologists is the utilization of operating room time through proper scheduling of cases. Surveys reported recently in the Bulletin of the New York State Society of Anesthesiologists and in the Bulletin of the California Society of Anesthesiologists [5] indicate that improper scheduling may be a national problem. Accurate records should be kept of the utilization of each operating room. An empty room represents a gross waste of skilled operating room nurses, anesthesiologists, and other personnel. The amount of time existing between induction of anesthesia and surgical incision is another cause for concern and should be minimized. Anesthesiologists may be partly responsible since they should define the scheduled time as either induction or incision time and remain consistent.

With rising costs in hospital care, it is imperative that expensive, highly technical areas such as surgical suites and its personnel be utilized to the fullest extent. With better organization and utilization of time, the specialty might be able to fulfill its obligation in the areas of obstetrical anesthesia and elsewhere. The use of anesthesiologists for outpatient surgery at times when the anesthesiologist would not be scheduled in operating room suites is provocative but would require integration of inpatient and outpatient facilities at a major level.[8]

Current Problems in Anesthesia

1. **Journals** There are six anesthesia journals: two American, two British, one Canadian, and one Scandinavian, exclusive of special periodicals such as *Survey of Anesthesiology*. The type of research paper currently being published is somewhat more complicated and more accurate than was available a generation ago. The clinician must interpret this information and utilize it in his practice. He is frequently disappointed. There is little doubt that *Anesthesiology* is one of the most erudite and fundamental journals in the United States today but, in achieving its scientific excellence, it sometimes evades the practitioner, who on occasion avoids *Anesthesiology*.

A solution may lie in the development of a third American journal of anesthesiology with a different approach. Its editors and "voices" might perhaps include private practitioners of anesthesia in addition to the academicians. Research papers submitted for publication would include brief introductions, short discussions and pertinent conclusions. Any detailed methods, results, and discussions would be available to interested readers. The possible significance of any research work would be discussed by an editor willing to "stick his neck out". Another medium

would be an anesthesia newsletter-periodical appearing once or twice a month. Employment of an experienced group of reporters guided by mature editors would lead to the creation of readable material.

2. **Meetings** The practice of having investigators report for ten or fifteen minutes, followed by a five minute discussion at various anesthesia meetings, such as the annual ASA meeting, should be stopped. These talks may be boring and are frequently unintelligibly presented by a nervous research Fellow and scheduled automatically, one following the other. It is difficult to believe that an initially interested audience grasps details and results of an investigation, usually impeccably performed, when half of the talk is devoted to analytical technique and protocol presentation. When a year or more of work is compressed into ten minutes, it is virtually hopeless to interest an audience already tired of viewing poorly prepared slides, sometimes projected upside down.

The format of such meetings might be changed to include investigators providing three one-hour audiences at announced times. Prepared handouts would be discussed before small groups of interested clinicians and fellow researchers, pertinent questions could be asked, and a gap in communications would be bridged. Thus, the major portion of such a meeting could be devoted to business, symposia, and exhibits.

3. **Flammable Anesthetics** Should ether and cyclopropane be banned from hospital practice? Some intelligent and influential professors and chairmen of departments of anesthesia believe they have no place in modern anesthesia practice. It costs approximately $2,000 extra to prepare an operating room for the safe use of explosive agents. The saving of $20,000 for an eight- to ten-room operating suite is attractive. The restriction of monitors, electrocautery, and mobility of personnel argues against their use when many nonexplosive safe agents are available.

On the other hand, statistics show that the incidence of an explosion is very low—about one per 100,000 flammable anesthetics. With proper precautions by all personnel, the chance for an explosion to occur is extremely low. If a very ill patient requires either cyclopropane to maintain blood pressure, or diethyl ether to manage cardiac arrhythmias, the use of these agents should not be denied. At the 1968 New York State Society of Anesthesiologists meeting, a poll of approximately 2,000 anesthesiologists was made and the vote was overwhelmingly against banning these agents.[9]

4. **The Halothane Dilemma** Halothane has been proven a safe and reliable anesthetic. It is nonexplosive, easily vaporized, and conveniently administered. Its actions are generally predictable as are its hypotensive and bradycardic side effects. Recovery from halothane is rapid and reasonably pleasant, with minimal central nervous system obtundation and a low incidence of emesis—formerly a common complaint.

However, halothane remains an extremely expensive drug at more than $20 for a four-ounce bottle (ether costs approximately 50¢ for the same amount). Halothane is used in combination with other agents such as thiobarbiturates, narcotics, nitrous oxide, and muscle relaxants, although it may rarely be used alone with oxygen. The stigma of hepatotoxicity has never been completely removed, but the relationship between agent and lesion has never been documented. It may be that in certain patients, halothane should not be used.

A primary problem concerns the training of "generations" of residents skillful in halothane administration but having little or no experience with diethyl ether, trifluoroethylene, fluoroxene, and methoxyflurane, etc. A problem with many anesthesiologists in practice and in training is nonversatility. The fact that conduction anesthesia in some areas of the country is not practiced because of medicolegal reasons constitutes another reason why general anesthesia, and therefore halothane, has become more popular.

5. **Acute Pulmonary Care** Presently, anesthesiologists, more than any other specialists, have busied themselves either on a part- or full-time basis with patients in need of intensive respiratory care. These patients may have a tracheostomy or an endotracheal tube inserted. They may be apneic and require intermittent positive pressure breathing. Such patients may be medical (emphysematous, bronchitic), surgical (postoperative), neurologic (Guillain-Barré), or pediatric (asthmatic). Hospitals and departments of medicine, surgery, neurology, and pediatrics have realized that death from malfunction of a ventilator or an error in respiratory care occurs more rapidly than from most other errors. Consequently, the need for an area specifically designed for the management of patients requiring the complicated nursing and medical treatment involved with intensive respiratory care has arisen. In those pilot centers where such respiratory care centers have functioned, mortality appears to have decreased significantly.[10]

Anesthesiologists have begun to seek occupation in such units. Their background is superb for this since they are well-trained in the use of ventilators, and their expertise in the management of obstruction, tracheal intubation, and respiratory gaseous agents is probably better than in any other specialty. The formation of a new medical specialty may be occurring and it is reasonable that, since cardiologists, endocrinologists, rhinologists, etc have evolved from parent specialties, a spin-off from anesthesia—the pulmonist —may occur. Such an individual would be involved in the care of the type of patients mentioned on a full-time basis and would have little to do with the ad-

ministration of anesthetic agents for the relief of surgical pain.

Simultaneously, the development of Sections on Inhalation Therapy and the growth of a group of technicians known as Inhalation Therapists have entered the scene.[11] Presently, there are about 700 Registered Inhalation Therapists in the United States. As of 1970, all candidates for Registry examination must have an Associate Degree or two years of college work which may include credit for inhalation therapy courses plus a type of "internship" year under medical direction before taking the Registry examination. They should, therefore, for equal length of training and similar importance in the care of patients, be at a level from a professional and pay standpoint equal to the three year diploma school Registered Nurse or the Associate Degree nurse on graduation. The logical specialist to supervise and train this professional individual is the anesthesiologist. The combination of the development of acute pulmonary care units and the specialty of inhalation therapy both under the care, guidance, and tutelage of anesthesiologists is a phenomenon and responsibility which must be recognized by our specialty at this time.

6. **Professional Liability** The number of malpractice suits and the amounts of subsequent awards have increased logarithmically in the past few years. Insurance companies have raised their premiums in a similar fashion. In some instances, anesthesiologists are unable to obtain malpractice coverage and this has led physicians to move to other states or to accept positions at government hospitals, where insurance is provided by the employer. Other physicians no longer teach residents in private hospitals, because premiums for coverage of negligent acts on the part of their trainees have become prohibitive. Most discouraging (in the face of the already inadequae number of anesthesiologists) is that some physicians reportedly have been forced to abandon the practice of anesthesia.[12]

Unfortunately, no single insurance company will underwrite anesthesiologists as a national group because they are in the highest risk category, and the American Society of Anesthesiologists is too small a group to undertake establishment of its own insurance company. Help *must* come through action from state medical societies. Only they are powerful enough to bring pressure on state legislatures and state insurance commissions for action. Anesthesiologists, by supporting and becoming more active in these societies, can bring about such changes. State insurance regulations can be enacted to change rules of evidence, limit the amounts of the awards, require patients to submit to arbitration and compel insurance companies to lower premiums. Without these changes, the medical care of patients will be adversely affected. Surely this argument must influence political officeholders and the legislature, and make them aware of the problem.

An alternative solution might be the requirement that patients have some type of hospital accident liability insurance. This would involve patient participation from a philosophical and financial standpoint.

REFERENCES

1. Beecher, H. K., et al: The Anesthetist as a Physician, *JAMA* **188**:49, 1964.
2. Papper, E. M.: The Manpower Crisis in Anesthesiology, *Medical Tribune*, March 23, 1966.
3. Medical Economics Continuing Survey, 1968. *Hospital Physician*, May, 1969.
4. Jenkins, M. T.: Chairman's Address: Section on Anesthesiology, read before the AMA 118th Annual Convention, July 13, 1969.
5. Ruttle, L. D.: Guest Editorial, *ASA Newsletter* **33**:2, April, 1969.
6. Ontario Perinatal Mortality Study Committee, Ontario Department of Health, 1967.
7. Editorial: Dental Anaesthesia, *Brit J Anaesth* **39**:449, 1967.
8. Cohen, D. D., and Dillon, J. B.: Anesthesia for Outpatient Surgery, *JAMA* **196**:1114, 1966.
9. Flammable Anesthetics Ignite Debate, *Medical World News*, January 31, 1969.
10. Campbell, D., et al: Four Years of Respiratory Intensive Care, *Brit Med J* **4**:255, 1967.
11. Wasmuth, C. E.: Guest Editorial, *ASA Newsletter*, **33**:2, 1969.
12. Engel, H.: Guest Editorial: It's Getting Worse, *ASA Newsletter*, **33**:2, 1969.

Predicting the Need for Ventilatory Assistance

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Normal man is capable of markedly increasing rate and depth of breathing in response to increased need. This ventilatory reserve may be diminished by anything which impairs function of the neural mechanisms regulating breathing (eg, overdosage of respiratory depressant drugs or bulbar poliomyelitis), reduces the mechanical efficiency of the thoracic cage (eg, flail chest syndrome), or increases the resistance to flow in the airways or lungs (eg, emphysema or pneumonia). The respiratory muscles must perform the necessary work to overcome thoracopulmonary resistance and provide adequate ventilation to maintain arterial blood O_2 and CO_2 at normal levels. Consequently, any condition which reduces the patient's ability to perform respiratory work, or which increases the thoracopulmonary resistance, reduces ventilatory reserve and may ultimately lead to ventilatory failure.

Preoperative evaluation of the patient's cardiorespiratory status is obviously a major responsibility of the anesthesiologist. In addition to determining the fitness of the patient to survive the alterations in physiology which occur during the perioperative period, and predicting the ultimate effect of the proposed surgical procedure on ventilation, the anesthesiologist must be able to anticipate the likelihood of the patient needing postoperative ventilatory support.

Physical examination of the patient, at rest before surgery, gives little information regarding ventilatory reserve. Observation of the excursion of the chest and auscultation of breath sounds are notoriously misleading guides to judging the adequacy of ventilation. Radiographic examination often fails to reveal evidence of functional abnormalities of the lungs. Considering the sedentary habits of our population, it is not surprising that even a careful history will fail to elicit clues to ventilatory limitations in many patients who are not in the habit of climbing stairs or taking long walks. Complex tests of pulmonary function are time consuming, expensive, and poorly correlated with the physiologic changes associated with various operative procedures. Consequently, they are of limited usefulness in evaluating the many patients who will undergo marked alterations in ventilatory ability during the perioperative period. Similarly, arterial blood gas determinations are of value only in assessing the adequacy of ventilation immediately before the blood

was drawn, and give no information regarding ventilatory reserve until there no longer is a reserve.

A major factor leading to postoperative pulmonary complications is the patient's inability, due to pain, to cough effectively and clear his airway of accumulated bronchial secretions. For a cough to be effective the patient must be capable of forcibly exhaling a sufficient volume of air at a high enough flow rate to sweep accumulated mucus out of the airway. Therefore any factor, such as muscle weakness or splinting of the respiratory muscles due to pain, which limits the volume of forced inhalation reduces the effectiveness of the cough. After maximal inhalation, pressure must be built up behind the closed glottis. For this reason, the effectiveness of coughing is reduced in any patient in whom an endotracheal tube or tracheostomy cannula is in place. Finally, during an effective cough, there is an explosive decompression of the lungs which develops a high expiratory flow rate. Consequently, conditions such as obstructive emphysema limit the maximal expiratory flow rate and reduce the effectiveness of the cough. Undoubtedly other abnormalities such as reduced minute volume, inability to sigh, etc, promote alveolar collapse and subsequent sequestration of organisms in the affected portions of the lungs. Measurement of Timed Vital Capacity (TVC) simulates the act of coughing, so that the test provides an adequate and convenient method of assessing the patient's ability to clear his airway of secretions.

Miller, et al,[1] correlated preoperative and postoperative TVC measurements with the clinical course of hundreds of patients. They found that even though appreciable degrees of restrictive or obstructive ventilatory disability existed, the patient was able to avoid ventilatory failure as long as TVC was above 25% of the predicted normal value. When TVC fell below this level, carbon dioxide retention ensued in the absence of ventilatory support. The presence of an appreciable obstructive component (reflected by a reduction in the volume exhaled in the first 0.5 sec of the test) compounded the problem.

For several years our department has used a modification of Miller's approach to provide a quantitative assessment of ventilatory reserve in patients who may be candidates for ventilatory support. We routinely measure TVC on all patients scheduled for upper abdominal or thoracic surgery, as well as those in whom history or physical examination suggest probable ventilatory limitation.

The test is simple to perform, and may be done on many patients in the course of a day's work. The patient is instructed to take the deepest possible breath and exhale as rapidly and completely as possible through a mouthpiece into a bellows spirometer.* The volume of this forced expiration is recorded on a calibrated chart which is moved at a standard rate of speed by an electric motor. The readout is a curve which relates volume in liters to time in seconds.

Figure 1 shows a typical tracing in a healthy adult. The volume exhaled is compared to a nomogram and expressed as a percentage of normal for the patient's sex and height. The volume exhaled in the first second of this single breath test ($FEV_{1.0}$) is expressed as a percentage of the patient's measured vital capacity.

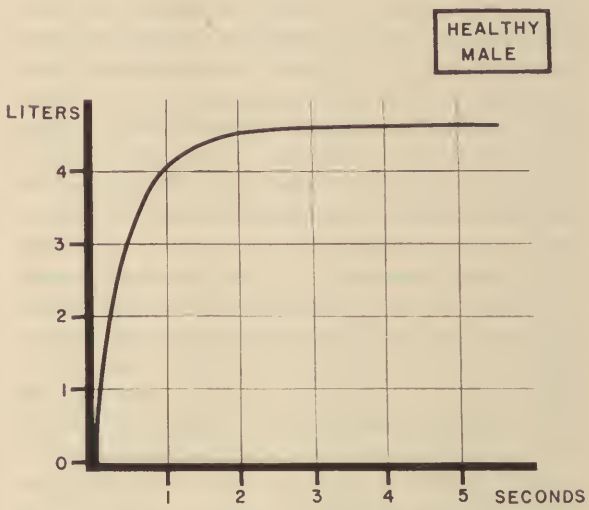


Fig. 1: Timed Vital Capacity tracing in a healthy adult. Volume exhaled (4.8 l.) is expressed as TVC = 100% of predicted normal. Forced expiratory volume exhaled in the first second (4.0 l.) is expressed as $FEV_{1.0} = 83\%$ of TVC.

Reduction of TVC below 80% of the predicted normal value indicates a reduced displaceable lung volume due to restrictive disease of the lungs or thorax. Reduction of $FEV_{1.0}$ below 75% of the patient's measured vital capacity indicates reduction of maximal expiratory flow rate due to obstructive disease of the lungs or airways. Figure 2 is a modification of Miller's quadrant system for identifying the nature and extent of ventilatory insufficiency. Test results on a normal individual lie in the upper right hand corner. Those with pure obstructive disease lie in the lower right hand area, while those with pure restrictive problems lie in the upper left quadrant. Patients with both restrictive and obstructive components lie in the large area at the lower left. The dotted curve labeled Marginal Reserve represents impending ventilatory failure. Patients whose test results lie above the curve may be normal, or have appreciable degrees of restrictive, obstructive, or mixed disabilities; yet they are capable of clearing their airways of accumulated secretions and ventilating themselves. If a patient's test results fall under the curve, he is likely to be in frank ventilatory failure, which can be confirmed by

* *McKesson Vitalor®*

arterial blood gas analysis. On the other hand, if his test results are on or just below the curve, he may be ventilating adequately at the moment but may lack sufficient reserve to continue to clear his airway and avoid ventilatory failure.

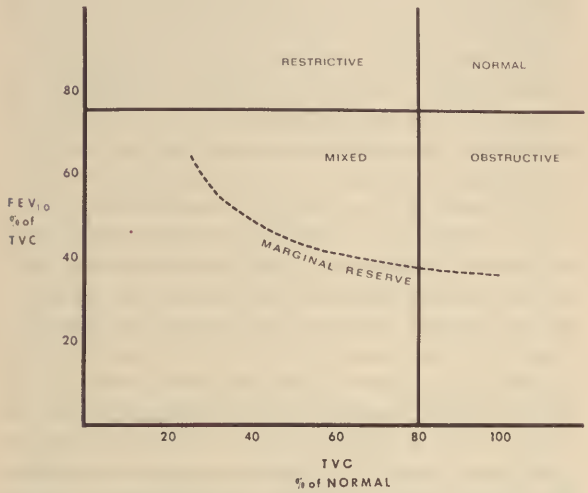


Fig. 2: Modification of Miller's quadrant system for defining the nature and extent of ventilatory insufficiency. Dotted curve indicates level at which ventilatory support should be instituted to avoid ventilatory failure.

Miller, in the 1950's, considered patients whose test results fell under the curve to be prohibitive risks for anesthesia and surgery. Our approach has been to institute ventilatory support whenever test results fall to, or below, the curve, even though arterial blood gas values may, at the time, be normal. Careful attention to thorough tracheobronchial toilette through an endotracheal tube or tracheostomy, and to providing controlled hyperventilation with a mechanical ventilator prevent development of atelectasis and ventilatory failure.

With modern anesthesiologic techniques, provision of adequate ventilatory assistance or control during the operative procedure rarely poses an unmanageable problem. However, anticipation of the need for postoperative ventilatory support is necessary if serious pulmonary complications are to be avoided. The effects of surgery on postoperative ventilation are due to pain in the operative site leading to muscle spasm, and are reasonably predictable. Surgery of the head, neck, extremities and perineum may be painful; but postoperative ventilation is unaffected since the respiratory muscles are not involved. There is an average reduction in TVC of 30% at the peak of postoperative pain following lower abdominal incisions, and a reduction of 50% after upper abdominal or thoracic incisions.[2] A further reduction must be anticipated if functioning lung tissue is removed during a thoracotomy.

Reductions of this magnitude may cause serious complications in patients with limited ventilatory ability before surgery. Figure 3 shows TVC tracings made on a patient preoperatively, and at the peak of pain after upper abdominal exploration. It can be seen that the preoperative TVC was less than 50% of the predicted normal value. At that time, physical examination did not indicate ventilatory limitation. Postoperatively the TVC fell below 25% of predicted normal. The patient developed ventilatory failure and required mechanical ventilation.

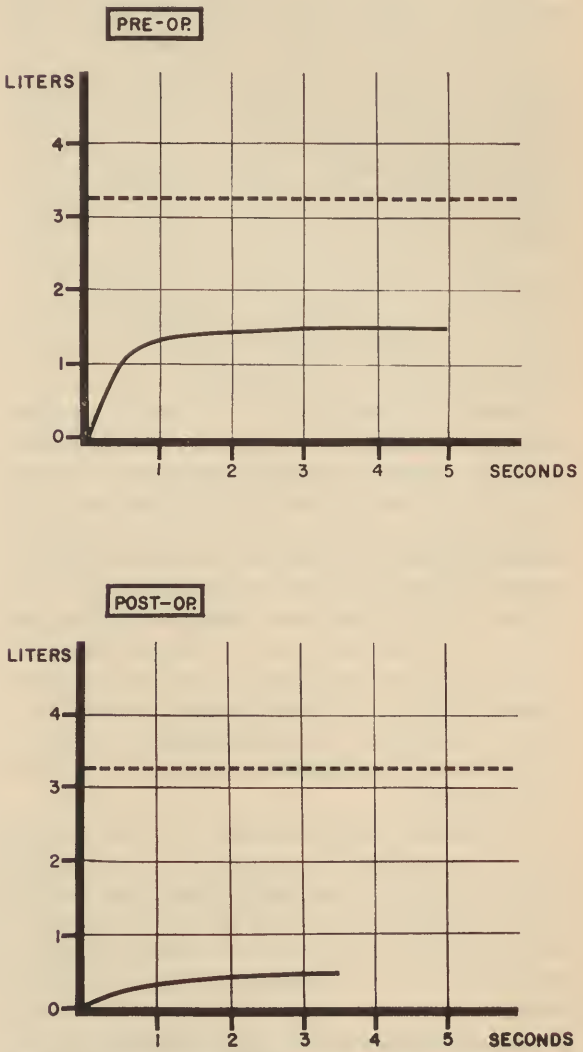


Fig. 3: Timed Vital Capacity tracings before and after upper abdominal exploration. Postoperative reduction in TVC and $FEV_{1.0}$ due to pain, was followed by ventilatory failure. Dotted lines indicate normal value for this patient.

The figures given for reduction of TVC after various operations are averages, and there are individual

variations in the response to pain. Only repeated measurements can be relied on in a given patient. It is important to note that the figures given represent the maximal reduction in TVC which occurs at the peak of postoperative pain. Postoperative pain usually is most pronounced on the second postoperative day. We commonly observe that TVC measured immediately after the patient awakes from anesthesia shows a less pronounced reduction than anticipated because of residual analgesia. In such cases, the test is repeated at intervals during the postoperative period, and supportive treatment is instituted if subsequent test results fall below the Marginal Reserve curve.

TVC which is reduced because of postoperative pain can be improved by effective analgesia. Under these circumstances, morphine usually produces a distinct improvement in TVC.[3] However, its use in the patient with severe ventilatory limitations may be undesirable because it depresses other parameters of ventilation. Morphine has been shown to reduce the intermittent sighing of conscious healthy people [4] which is an important protective mechanism in preventing alveolar collapse. We have recently observed that awake analgesia with methoxyflurane, self-administered by patients after upper abdominal or thoracic surgery, produces as much improvement in TVC as 10 mg morphine without the depression of alveolar ventilation observed after morphine.[5]

Accurate measurement of TVC cannot be made while an endotracheal tube or tracheostomy cannula is in place. However, a useful approximation of total vital capacity can be recorded, provided the endotracheal tube or tracheostomy cannula is fitted with an inflated cuff. The maximal volume the patient is capable of exhaling can be recorded by means of an accurate and portable ventilometer.* This approximation can be recorded even in unconscious or uncooperative patients by measuring the volume of air coughed by the patient when the endotracheal tube is moved. This cannot be accomplished, of course, in a deeply unconscious patient, or one with a depressed cough reflex.

Candidates for thoracic surgery pose special problems. It is necessary to predict both the adequacy of ventilation during the immediate postoperative period and the ultimate effect of the surgical procedure on ventilation. In our practice, most patients scheduled for thoracotomy have some preoperative ventilatory limitation. Pain from the thoracotomy incision causes an average reduction of 50% of the preoperative TVC. A further reduction must be anticipated which is proportional to the amount of functioning lung tissue removed during the operation. Since the reduction in function due to incisional pain can be compensated for by proper tracheobronchial toilette and a mechanical ventilator, the important question to be answered is the ultimate ventilatory ability after pain subsides.

Although a patient with a single healthy lung can live a very active life after he has recovered from surgery, often pulmonary resection is proposed on patients with bilateral disease. In these cases it is necessary to determine in advance that a disproportionate amount of functioning lung tissue will not be removed. Function is normally distributed 45% in the left and 55% in the right lung. This distribution is often grossly altered by pathology. Separate and simultaneous spirographic examination of each lung through a Carlens double lumened endotracheal tube provides the best guide to the true distribution of function between the two lungs.[6] Pneumonectomy may cause no reduction in function if the resected lung was already functionless, while lobectomy may have serious consequences if the lung on the operative side was responsible for most of the preoperative function. Those patients whose functions will lie on or under the Marginal Reserve curve after the immediate effects of surgery subside are considered prohibitive risks for the proposed operation. If the operative procedure is carried out, either the patient will develop ventilatory failure when removed from the ventilator, or will have so little reserve that ventilatory failure will be precipitated by minor pulmonary infections. When the situation is predicted, the operative procedure must be modified or an alternative form of therapy must be found. Sometimes the ultimate effect of surgery on ventilation is an improvement when a nonfunctioning space occupying lesion is removed, when pleurectomy releases a restricted lung, or when pulmonary congestion is relieved by a cardiac procedure.

As a measurement of TVC which falls below the Marginal Reserve curve indicates the need for ventilatory support, similarly, serial measurements which rise above the curve with subsiding pain or improvement in the patient's pathology indicate that it is safe to begin weaning him from support. During this process it must be remembered that use of mechanical ventilators puts the respiratory muscles at rest with a consequent loss of muscle tone. If ventilator support is abruptly withdrawn, excessive fatigue may cause the patient to underventilate. It also is necessary to extubate the trachea or close the tracheostomy as soon as it is no longer essential for tracheobronchial toillette, since a truly effective cough cannot be produced until the patient is able to build up pressure behind a closed glottis.

The following case is illustrative of the usefulness of this approach in predicting a patient's postoperative course:

A 57-year-old woman, 60 inches tall, was scheduled for correction of severe mitral stenosis with a history of congestive heart failure. Her predicted normal TVC was 3000 ml. Preoperatively her measured

* *Wright Respirometer®*

TVC was 1100 ml, or 36% of predicted normal. Her $FEV_{1.0}$ was 850 ml, or 77% of the measured TVC. This represented a severe restrictive ventilatory disability without an appreciable obstructive component. It was thought that the restriction was due to pulmonary congestion with probable interstitial fibrosis, and that this might be partially alleviated by correction of the valvular defect. It was predicted that she would require ventilatory support during the immediate postoperative period, and that her ventilatory ability would improve to or above the preoperative level as postoperative pain subsided.

Mitral valvulotomy was performed through a midline sternal splitting incision. At the end of the procedure, her nasotracheal tube was connected to an Emerson respirator, and mild continuous hyperventilation was begun. During the evening of the day of operation the volume she was able to cough through the endotracheal tube was found to be 750 ml. On the morning of the first postoperative day this volume had decreased to 300 ml. On the second postoperative day the volume coughed was about 700 ml. It was decided to replace her nasotracheal tube with a tracheostomy for greater patient comfort and security. On the fourth postoperative day she was able to cough 1000 ml, or 33% of predicted normal TVC. She was removed from the ventilator and repeated arterial blood gas determinations were within normal limits. The tracheostomy was closed to permit her to cough more effectively. There were no postoperative complications and she was discharged from the hospital on the fourteenth postoperative day. At that time her TVC was 46% of predicted normal and the $FEV_{1.0}$ was 78%.

This simple test should be interpreted with certain reservations. Like any laboratory test it is a supplement to other knowledge regarding the patient's condition, and it should not provide a basis for treatment when the test results contradict everything else that is known about the patient. Although the test is not highly precise, duplicate determinations should check within 100 ml if the results are reliable. The test measures only a single forced expiration and does not give a total picture of the patient's ability to ventilate himself. For the test to be reliable, the patient must understand what is expected of him and must be willing to cooperate. He must be able to make a leakproof seal with his lips around the mouthpiece. Most erroneous test results are falsely low because the patient does not understand or will not do what is desired, is edentulous and cannot prevent leaks, etc. Occasionally the test can be misleading on the high side. A patient with inspiratory airway obstruction, for example one with flaccid vocal cords, may be able to inhale slowly and then produce a normal forced expiration, even though he has severe ventilatory limitations. A patient with myasthenia gravis often can produce a single normal forced expiration but fatigues with repeated efforts. In either case the extent of ventilatory limitation is better demonstrated by measurement of maximal breathing capacity.

TVC measurements, interpreted in this fashion, provide a useful guide to safe institution and withdrawal of ventilatory support in many conditions, other than postoperative pain, which may lead to ventilatory failure. The same approach is applicable to the patient with progressive ventilatory insufficiency from bulbar poliomyelitis, Barré-Guillain syndrome, flail chest from multiple rib fractures, etc. The test does not provide guidelines for use of mechanical ventilators for such purposes as controlling pulmonary edema or production of respiratory alkalosis to reduce intracranial pressure.

REFERENCES

1. Miller, W. F., Wu, N. and Johnson, Jr., R. L.: Convenient method of evaluating pulmonary function with a single breath test. *Anesthesiology* **17**:480-493, 1956.
2. Beecher, H. K.: The measured effect of laparotomy on the respiration. *J Clin Invest* **12**:639-650, 1933.
3. Masson, A. H. B.: Clinical assessment of Analgesic drugs. *Anesth & Analg* **41**:615-622, 1962.
4. Eckenhoff, J. E., Helrich, M., Hege, M. J. D., and Jones, R. E.: Respiratory hazards of opiates and other narcotic analgesics. *Surg Gynec Obstet* **101**:701-708, 1955.
5. Yakaitis, R. W., and Redding, J. S.: Unpublished data.
6. Gaensler, A. E.: Preoperative evaluation of lung function. Internat. *Anesthesiol Clin* **3**:249-275, 1965.

Problems in the Management of Drowning Victims

Over 6,000 people die from drowning each year in the United States. Most of them are young and in good health. No single disease kills as many people under 24 years old.[1] In spite of the magnitude of the problem, relatively little is known about this fatal accident.

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Pathophysiology

Postmortem examination of drowning victims often shows a striking light pink coloration of the skin suggestive of carbon monoxide poisoning. Goose flesh is common. Frothy pulmonary edema fluid usually fills the lungs and airway and exudes from the nose and mouth. The lungs appear hyperexpanded, and petechial subpleural hemorrhages are common. Microscopic examination may reveal seaweed, sand, mud or algae in the lungs and airway. There is diffuse capillary congestion of the alveolar walls. The upper gastrointestinal tract may be filled with ingested fluid and foreign material. Biochemical and morphologic alterations in the blood may be discovered. These changes only suggest the drastic physiologic alterations which precede death.

Although detailed observations on humans during the process of drowning have not been reported, experimental evidence indicates that submersion is followed by a period of breath holding and struggling [2] of markedly variable duration. This is followed by swallowing of large volumes of water and vomiting. Laryngospasm may prevent flooding of the lungs until asphyxia produces flaccidity. Some victims may die during the process of asphyxia, before water enters the lungs. As asphyxia progresses, the victim's glottic muscles relax, and subsequent events are determined by the composition of the fluid which floods the lungs.

In fresh water drowning, large volumes of water pass with extreme rapidity through the lungs into circulation. There is marked hemodilution with massive hemolysis and lowering of blood concentrations of sodium, chloride, calcium, and plasma proteins.[3] Should both asphyxia and hyponatremia from the hemodilution be severe enough, sudden ventricular fibrillation may be the cause of death. If fibrillation does not occur, or if it is corrected, the massive hypervolemia results in fulminating pulmonary edema and heart failure.

Sea water contains 3.5% mixed salts. It is markedly hypertonic compared to blood. When sea water is aspirated, these salts diffuse into the blood with rapid elevation of the plasma sodium. The osmotic effect of the sea water causes loss of large amounts of fluid from the circulation into the lungs. As the alveolar membrane is damaged, plasma protein is also lost into the lung fluid. The end result is a fulminating pulmonary edema, hypotension, bradycardia, and death.

Resuscitation

Most victims of submersion will either survive spontaneously, not having been submerged so long that resuscitation is necessary, or will be beyond any help. It must be remembered that the apparent duration of submersion is a very unreliable guide to the physiologic condition of the victim.

When a victim is removed from the water, breathing and vigorous coughing suggest that hypoxic damage is slight and that little water has been aspirated. If the patient is conscious, and not cyanotic, he should be transported to a hospital for physical examination, chest X-ray, and examination of blood and urine.

If there are no breathing movements, time must not be wasted. No attempt should be made to drain water from the lungs since this cannot be accomplished effectively.[4] The pharynx should quickly be cleared by the rescuer's fingers and the head and jaw properly positioned to relieve soft tissue obstruction of the airway. Exhaled air resuscitation is then started immediately. The lungs can be ventilated by blowing through any fluid which may be in the airway. After the first successful lung inflation, the pulse in the carotid artery should be checked. If it is not palpable, closed chest cardiac massage must be started and continued along with artificial ventilation of the lungs. Intermittent positive pressure breathing with oxygen should be substituted for exhaled air as soon as the necessary equipment becomes available. Both artificial respiration and closed chest cardiac massage must be continued while the victim is transported to a hospital. Cardiac massage may be discontinued if a spontaneous pulse becomes palpable in the carotid. Positive pressure ventilation should not be discontinued even if spontaneous breathing efforts return. In this event, the victim's inspiratory efforts should be assisted with positive pressure oxygen.[5]

Definitive Treatment

When the victim reaches a hospital, if a spontaneous pulse is still not palpable, 1 mg of epinephrine should be injected by the intracardiac or intravenous route. The dose should be reduced for children under 18 months of age. If there is electrocardiographic evidence of ventricular fibrillation, external countershock should be used to correct it.[6] Artificial respiration and circulation should be continued, along with intravenous administration of peripheral vasoconstrictor drugs such as phenylephrine or methoxamine, until spontaneous circulation is restored.

Once spontaneous circulation is restored, blood and urine should be examined, a chest X-ray should be taken, and an adequate physical examination performed. Intermittent positive pressure breathing should not be discontinued at this time. Tracheal intubation should be used to facilitate mechanical ventilation for the first 48 hours. If a respirator is needed for longer periods, it is usually advisable to replace the tracheal tube with a tracheostomy. Fluid and electrolyte redistribution occurs very rapidly after aspiration of either fresh water or sea water. Blood specimens drawn 30 to 60 minutes after aspiration may reveal little evidence of the magnitude of the physiologic insult. If a serious degree of hemolysis has occurred in victims of fresh water drowning, partial exchange transfusion may be considered. Following sea water aspiration, administration of plasma may be essential to restore the circulating blood volume.[7] In either type of drowning, monitoring of the central venous pressure provides a minute-to-minute indication of the effectiveness of treatment. The following cases illustrate some of the difficulties encountered in managing drowning victims after successful resuscitation and correction of the circulatory alterations resulting from asphyxia and massive aspiration.

Case 1 (Fresh Water Drowning): A previously healthy 10-year-old white boy received successful cardiopulmonary resuscitation after drowning in a fresh water river. He was received in the emergency room 30 minutes later, at which time he was obtunded and made frequent wild, purposeless movements. Vital signs were: BP 160/80, P 140, R 58, T 104°F. His pupils were small and reacted to light. Ronchi were heard throughout both lung fields, and chest X-ray showed bilateral pulmonary densities suggesting pulmonary edema. Studies of blood and urine were not remarkable.

An anesthesiologist administered O_2 and passed a nasotracheal tube to facilitate positive pressure breathing with an Emerson (volume cycled) respirator delivering 50%-80% O_2. Later that evening a tracheostomy was performed, and an indwelling urethral catheter was inserted. Urine output ranged from 15-65 ml/hr.

Ampicillin and hydrocortisone were started intravenously. To minimize cerebral edema body temperature was reduced to 30.5°C. To prevent shivering during the process of cooling, meperidine, chlorpromazine and curare were given.

Next day the child remained comatose, chest X-ray showed marked improvement of the pulmonary edema, and an electroencephalogram indicated probable damage in the left temporal and right frontal regions. Hypothermia, ampicillin and hydrocortisone were continued.

On the third day, hypothermia was discontinued and cultures of tracheobronchial secretions were negative for pathogens. The fifth day after drowning, the patient was noted to be more responsive and the following day he was alert and able to take a full liquid diet.

One week after admission, an attempt was made to withdraw respirator support. Tachypnea and cyanosis quickly developed. Spontaneous breathing

of 100% O_2 for periods of 10 to 15 minutes every two hours was tolerated fairly well. Chest X-ray showed a recurrence of bilateral infiltration and consolidation.

During the next two days the lung findings failed to improve, coagulase positive staphylococci sensitive to all antibiotics and pseudomonas organisms were cultured from the tracheobronchial secretions, temperature rose to 100°-102°F, and the WBC rose to 30,000. Antibiotic therapy was intensified and the O_2 concentration used to ventilate the patient was reduced to 35%-45%.

Eleven days after being resuscitated, while using a bed pan, the patient suddenly fell back and asystole was noted on the cardiac monitor. Resuscitative efforts failed.

At autopsy the lungs appeared fibrotic and an extensive thrombosis was found in the right pulmonary artery. Histologic sections demonstrated pulmonary hyaline membranes, pneumonitis, thromboembolism and focal infarction. These changes were considered to be compatible with the effects of both aspiration and O_2 therapy.

Case 2 (Sea Water Drowning): Cardiopulmonary resuscitation restored spontaneous pulse and respirations in a previously healthy 47-year-old white man 20 minutes after he drowned in sea water. He was received in the emergency room 30 minutes later and was noted to be semiconscious and hyperactive, with BP 140/90, P 60. He was tachypneic but not cyanotic. Pupils were partially dilated but reacted to light. He was bleeding from the right ear and mouth. Loud ronchi were heard in both lungs and there were crepitant rales in both bases. Chest X-ray showed patchy areas of consolidation in both lungs, most pronounced in the right lower lobe. Blood and urine studies were not remarkable.

An anesthesiologist administered O_2 and failed to intubate the trachea because of large amounts of blood in the pharynx. A tracheostomy was performed and a large pharyngeal laceration was discovered and sutured. Ventilation by means of a Bennett MA-1 (pressure cycled) respirator using 40% O_2 was begun. A nasogastric tube and bladder catheter were inserted. Body temperature was reduced to 90°-92°F while meperidine and curare were used to prevent shivering. Chloramphenicol and hydrocortisone were started, the patient was given ethylcrynic acid and he was digitalized. An electrocardiogram showed no evidence of myocardial damage.

Next day the patient was still semiconscious. While being ventilated with 40% O_2 his arterial blood revealed PO_2 85 mmHg, PCO_2 40 mmHg, and pH 7.30. Hypothermia was discontinued.

On the fifth day the patient was transferred to another hospital while being artificially ventilated. He had become alert and responsive, and chest X-ray showed considerable clearing of the right lower lobe. He was placed on an Emerson respirator utilizing 44% O_2. At that time his arterial blood showed PO_2 37 mmHg, PCO_2 36 mmHg, and pH 7.44. The inhaled O_2 concentration was increased to 72%. His temperature rose to 103°F and cooling was reinstituted.

The patient continued alert and oriented until the eighth day. Cooling was necessary to prevent hyperthermia, and pseudomonas aeruginosa was cultured from the tracheal secretions. Appropriate antibiotics were given. It was found necessary to gradually increase the O_2 concentration delivered by the respirator in order to prevent a dangerous fall in arterial PO_2. On the eighth day after drowning, the patient was cyanotic in spite of hyperventilation with 100% O_2. Arterial PO_2 had fallen to 33 mmHg. Four consecutive episodes of ventricular fibrillation occurred, and resuscitative efforts failed on the fourth attempt. Permission for autopsy was denied.

Case 3 (Sea Water Near-Drowning): A previously healthy 16-year-old white man was removed unconscious from sea water but cardiopulmonary resuscitation was unnecessary. He was taken to a hospital where he regained consciousness, and was given O_2 by mask and hydrocortisone intravenously. A nasotracheal tube was inserted by an anesthesiologist, and a laceration of the right ear was sutured. He was then transferred to another hospital.

On admission he was comfortable and acyanotic. Diffuse ronchi were heard in both lungs and chest X-ray revealed generalized haziness and infiltrative densities throughout both lung fields. Arterial blood revealed PO_2 42 mmHg, PCO_2 40 mmHg, and pH 7.23. He was placed on a Bird (pressure cycled) respirator delivering 100% O_2. Hydrocortisone was given intravenously.

Next day he was alert and responsive and chest X-ray showed definite clearing of the pulmonary infiltrates. An attempt was made to ventilate him with air, but the arterial PO_2 fell to 45 mmHg. The O_2 concentration was maintained at 30% during the night.

On the third day his chest X-ray showed further improvement and his vital capacity was 1800 ml. He was allowed to breathe air spontaneously, and was then extubated. Tracheal cultures from the previous day showed D pneumoniae. He was treated with penicillin and was discharged after being afebrile for 48 hours. Chest X-ray on discharge showed only a slight infiltration in the right middle lobe.

Discussion

Rapid and specialized attention to many facets of care is necessary in managing a patient after resuscitation from drowning. Immediately following restoration of spontaneous circulation, the patient's state of consciousness is the best indication of success in preserving cerebral function. Usually the victim is obtunded, and the earlier reflex activity returns, the

more likely he is to recover fully. Steadily progressive return of consciousness is encouraging compared to those patients who show plateaus during which no progress is observed. The electroencephalograph may be of assistance in following the course of returning cerebral function.

It is desirable to cool the obtunded patient's body temperature to about 30°C without delay after resuscitation. This reduces cerebral oxygen consumption and carbon dioxide production. Shivering, with an increased metabolic rate, may be prevented by the use of narcotics or neuromuscular blocking agents.

Asphyxia and circulatory arrest lead to cerebral edema. The resulting increase in intracranial pressure results in further death of cells. Passive hyperventilation on a respirator, which produces respiratory alkalosis and cerebral vasoconstriction, and osmotic diuresis are aimed at reduction of the intracranial pressure.

Massive doses of steroids should be given intravenously as soon as possible after resuscitation. The purpose is twofold—to prevent cerebral edema and to minimize the inflammatory response to aspiration of fluid, often mixed with gastric contents.

Once the circulatory disturbances are controlled, the most severe problem in the continued management of any patient who has been resuscitated from drowning is arterial hypoxemia and acidosis.[8] Loss or alteration of lung surfactant material and damage to the alveolar membrane lead to extensive areas of nonventilated lung through which pulmonary blood flow is shunted. Consequently, arterial blood should be drawn for determination of pH, PCO_2, and PO_2 as soon as possible. This makes possible accurate correction of metabolic acidosis with sodium bicarbonate. Ventilation of the patient with the respirator should be regulated to produce a moderate degree of respiratory alkalosis, and the percentage of oxygen in the inhaled gas mixture should be adjusted to maintain arterial PO_2 in the range of 60-90 mmHg.

Pulmonary shunting usually subsides over a period of 48 to 72 hours. Consequently, repeated arterial blood gas determinations are necessary to regulate the degree of ventilation and the inhaled oxygen concentration as the status of the lung changes. It is important to avoid giving excessive oxygen concentrations since further damage to the alveoli may result,[9] but it is imperative to give as high a concentration as necessary to prevent dangerous arterial hypoxemia. Constant attention is necessary to humidification of the inhaled gas, asepsis during suctioning of tracheal secretions, artificial coughing and sighing, and frequent changes in the patient's position. When the severity of the pulmonary shunt subsides, as indicated by the arterial blood gas determinations, spontaneous breathing may be permitted, but supplementary oxygen is often still necessary.

Pulmonary infection is a common complication in the patient who has a tracheostomy or endotracheal tube in place,[10] and this problem is magnified in the drowning victim in whom the damaged respiratory membrane presents a tremendous abraided surface for secondary bacterial contamination. Consequently frequent cultures must be taken, and the appropriate antibiotic therapy must be intensive.

In the three cases presented, certain features are of interest. Resuscitation of the two victims of drowning was successful. Circulation was restored and controlled, and cerebral damage was prevented since both patients were conscious and oriented. The pulmonary sequelae of aspiration were effectively managed by diligent attention to artificial ventilation with oxygen concentrations necessary to prevent recurrence of circulatory arrest. However, the prolonged use of high oxygen concentrations necessitated by the severity of the damage may have caused further alveolar changes. Bacterial invasion then contributed to the outcome. The third case was treated for near-drowning (submersion and aspiration, without circulatory arrest) and ultimate recovery may have been due to the lesser magnitude of the insult.

Management of the drowning victim can be considered to involve three phases:

1. Initial resuscitative measures must be started as soon as the victim is recovered from the water, and continued during transportation to a hospital where any definitive measures can be carried out to restore spontaneous circulation and control circulatory abnormalities.

2. There must be no delay in effective treatment aimed at minimizing cerebral edema and the inflammatory response to aspiration.

3. Extensive pulmonary shunting must be compensated by continued mechanical ventilation with whatever oxygen concentrations are necessary to prevent arterial hypoxemia, and secondary bacterial pneumonitis must be prevented or controlled.

REFERENCES

1. Imburg, J. and Hartney, T. C.: Drowning and the treatment of non-fatal submersion. *Pediatrics* **37**:684, (April) 1966.
2. Fainer, D. C., Martin, C. G., and Ivy, A. C.: Resuscitation of dogs from fresh water drowning. *J Appl Physiol* **3**:417, 1951.
3. Swann, H. G. and Spafford, N.R.: Body salt and water changes during fresh water and sea water drowning. *Texas Rep Biol Med* **9**:356, 1951.
4. Ruben, A. and Ruben, H.: Artificial respiration—flow of water from the lung and the stomach. *Lancet* **1**:780, (April 14) 1962.
5. Redding, J. S., Cozine, R. A., Voight, G. C. and Safar, P.: Resuscitation from drowning. *JAMA* **178**:1136, 1961.
6. Redding, J. S. and Cozine, R. A.: Restoration of circulation after fresh water drowning. *J Appl Physiol* **16**:1071, 1961.
7. Redding, J. S., Voight, G. C. and Safar, P.: Treatment of sea water aspiration. *J Appl Physiol* **15**:1113, 1960.
8. Modell, J. H., Davis, J. H., Giammona, S. T., Moya, F. and Mann, J. B.: Blood gas and electrolyte changes in human near-drowning victims. *JAMA* **203**:337, (Jan. 29) 1968.
9. Nash, G., Blennerhassett, J. B. and Pontopiddan, H.: Pulmonary lesions associated with oxygen therapy and artificial ventilation. *New England J Med* **276**:368, (Feb. 16) 1967.
10. Gotsman, M. S. and Whitby, J. L.: Respiratory infection following tracheostomy. *Thorax* **19**:89, 1964.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on Saturday, December 13, 1969, and took the following actions:

1. Approved two travel requests for 1970, prior to preparation and approval of the 1970 budget;
2. Authorized the Executive Secretary, on an annual basis, to establish suitable closing and opening schedules for the Faculty building during the Christmas and New Year holidays;
3. Authorized an annual Christmas party for the staff;
4. Deferred action on proposed Radiation Control Regulations until they have been given further study;
5. Adopted proposed Blood Bank regulations as requested by the Department of Health and Mental Hygiene;
6. Heard that a chiropractor was not qualified to testify as a medical expert in a case before the State Court of Appeals; and that the Amicus Curiae brief filed by the Faculty in this regard had not been ruled on;
7. Decided to reaffirm its previous position concerning services provided by a physician to Medicare patients;
8. Declined to discuss further the question of the bond issue for the Physicians Memorial Hospital in La Plata, as a result of a letter sent to a Council member asking for his intercession in this matter;
9. Determined that the Program and Arrangements Committee should endeavor to schedule the Annual Meeting later in the spring; and encouraged staff to prepare as many annual reports as possible for consideration by the House at the 1970 annual session;
10. Deferred action until the next meeting on (a) a proposed questionnaire to be distributed to Faculty members discussing services of the Faculty and (b) discussion of a feasibility study in connection with medical economics;
11. Agreed to cooperate with the Drug Abuse Authority in a proposed study of the Attitude of Physicians to Treatment of Drug Abusers;
12. Adopted a statement and resolution on Hazards of Cigarette Smoking (see below);
13. Deferred action on a resolution concerning Transportation of Psychiatric Patients, until further information can be obtained;
14. Referred a proposal dealing with arbitration panels for professional liability cases to the Medical Economics Committee;
15. Approved the principle that the Medical Board for Occupational Diseases be continued as presently constituted in the law;
16. Deferred action on a proposed model Food and Drug Law for Maryland until it can be studied further.

The House of Delegates met on Saturday, December 13, 1969, and in special session adopted bylaw amendments that would clearly define the term "physician's defense," and what is covered by this expression. (Copy of the Bylaw changes are available on request)

Resolution Regarding Hazards of Cigarette Smoking

Submitted by Ad Hoc Committee to Develop a Resolution on the Hazards of Cigarette Smoking, of the Committee on Postgraduate Education, Preventive Medicine, and Public Health: John B. De Hoff, MD. Chairman, James D. Carr, MD, Jason Geiger, MD, Robert J. Wilder, MD.

Whereas, the physicians of this State recognize that cigarette smoking is dangerous to health and may cause death from cancer, coronary heart disease, chronic bronchitis, pulmonary emphysema, and other diseases, and

Whereas, the Surgeon General of the U. S. Public Health Service has estimated that 300,000 premature deaths and several million additional cases of serious illness and disability which are causally related to cigarette smoking occur each year in the United States, and

Whereas, the cigarette smoking habit usually begins in early adolescence, and

Whereas, the Medical and Chirurgical Faculty of Maryland is concerned in all matters relating to the public health; therefore be it

Resolved, that the Medical and Chirurgical Faculty of Maryland takes a strong stand against smoking; and be it further

Resolved, that the Faculty urges its members to work to eliminate cigarette smoking by personal example and by advice regarding the health hazards of smoking; and be it further

Resolved, that the Faculty will discourage smoking by public pronouncements, and by educational programs especially directed to young people; and be it further

Resolved, that the Faculty will discourage the sale of cigarettes in public and private diagnostic treatment and rehabilitation centers in Maryland; and be it further

Resolved, that, through appropriate channels, the Faculty will indicate to the Congress of the United States and to the Legislature of the State of Maryland the incongruity of spending tax dollars to promote or support the production and sale of tobacco while at the same time spending other tax dollars to discourage cigarette smoking because of its hazard to health.

Adopted by the Executive Committee Dec. 13, 1969

Current Reimbursement Policies of the Maryland Medical Assistance Program

Because of seeming confusion in connection with Medicaid payments to physicians throughout the State, the following brief summary of current policy in this regard is provided:

In-Hospital

For in-hospital services, private physicians with private Medicaid patients are reimbursed $10 for the first day and $3 for each subsequent day the patient is hospitalized for medical services. For surgical services the physician is reimbursed at a fee for the particular procedure rendered. This surgical fee is in lieu of the above medical reimbursement. The surgical reimbursement in most cases amounts to approximately 50% of the Usual, Customary and Reasonable fees published by the Faculty in their 1966 Fee Guide.

Home & Office

Office visits	up to $5
Home day visits	up to $6
Home night visits	up to $7

Other services which are reimbursed *in addition* to the office visit are as follows:

a) Diagnostic X-rays
50% of Professional Component in the Department of Health Diagnostic Radiology Procedure and Fee List—March 1, 1968.

b) Laboratory tests
50% of Department of Health Fee Schedule for Laboratory Procedures.

c) Dispensed or injected medications
Actual cost of drugs as verified in the Red Book or Blue Book when said drug costs the physician 50¢ or more.

d) E.K.G.
Including interpretation and report—$7.50.

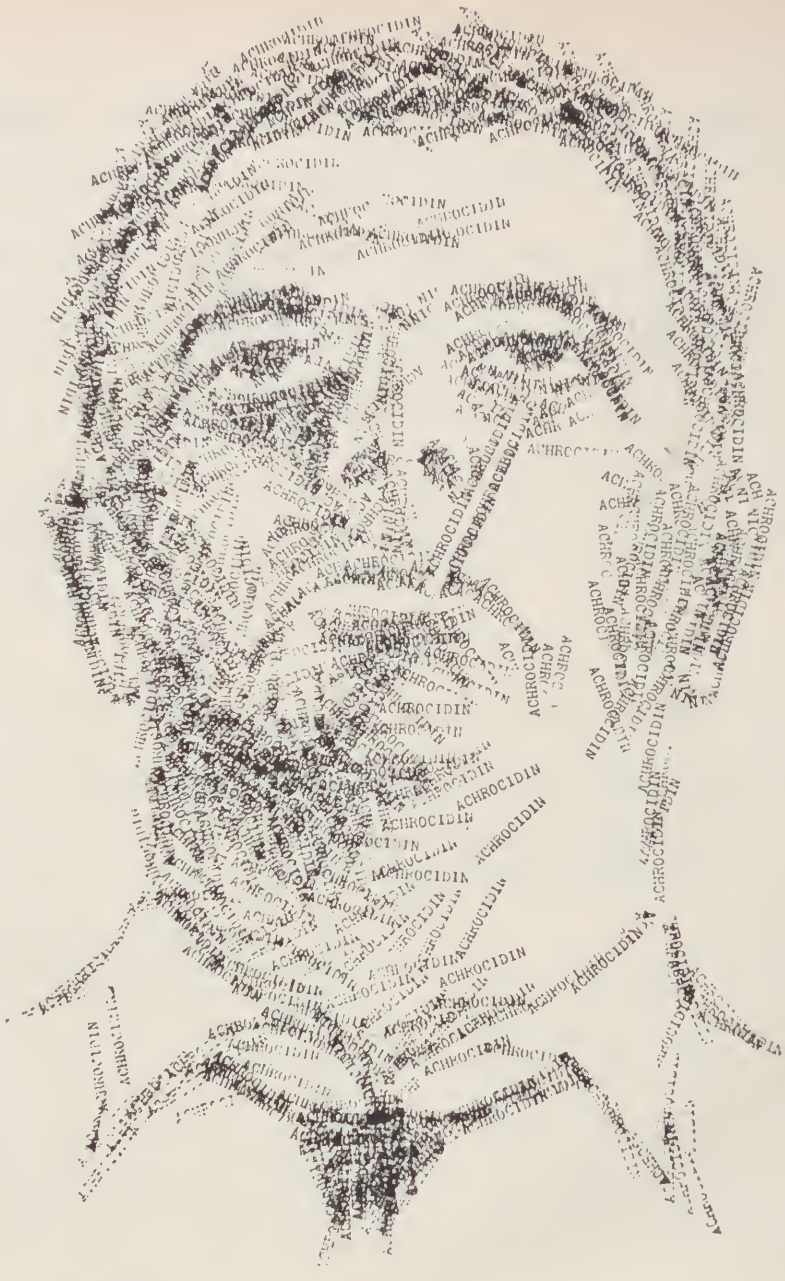
e) E.E.G.
Including interpretation and report—$12.50.

f) Diathermy, Infra-red or Ultraviolet when administered by a physician—$2.50 per treatment.

Consultations

Additional allowances are made for the services of a consultant. Any physician with a specialty, and who has filed the required papers with the Medical Assistance Program, may be classified as a Consultant Specialist. Reimbursements to a Consultant Specialist for a "consultation" which was requested by the patient's attending physician is reimbursable at $20 for the first visit and $7 for subsequent visits. Consultations rendered by physicians not having Consultant Specialist status with the Medical Assistance Program are reimbursed at $10 for the first visit and $5 for subsequent visits. These fees are applicable to both ambulatory patients as well as in-hospital patients.

It is requested that all physicians continue to bill at their usual and customary charges even though reimbursement in most cases will be considerably less than this amount.



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Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliativ dermatitis; photosensitivity; onycholysis, na discoloration. *Kidney*—dose-related rise BUN. *Hypersensitivity reactions*—urticari angioneurotic edema, anaphylaxis. *Intracran* —bulging fontanels in young infants. *Teeth* yellow-brown staining; enamel hypoplasi *Blood*—anemia, thrombocytopenic purpur neutropenia, eosinophilia. *Liver*—cholestasis a high dosage.

Upon adverse reaction, stop medication an treat appropriately.

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All requests subject to confirmation.

ARTS AND HOBBY EXHIBIT

Annual Meeting of the Medical and Chirurgical Faculty

APRIL 1, 2, 3, 1970 The Alcazar, Baltimore

APPLICATION FOR ARTS AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Arts and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height: .....

3. Electrical or other requirements: .....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

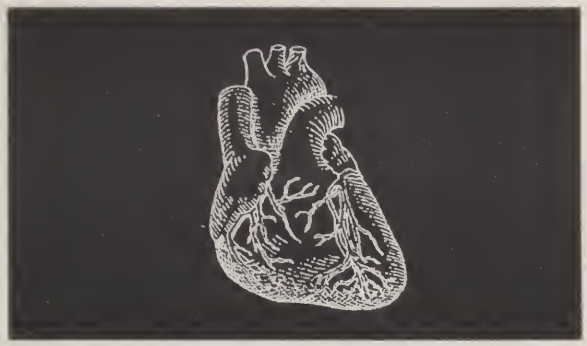
An Arts and Hobby Exhibit will be held during the 172nd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible. Entries will be accepted until all exhibit space is allotted. Please have exhibits framed or mounted.

Entries should be delivered to The Alcazar, Cathedral and Madison Streets, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, March 31. They must be removed on Friday, April 3, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit.

Certificates will be awarded to the prize-winning exhibits. The names of exhibitors received by February 1, 1970, will be listed in the printed Annual Meeting program. However, all entries should be submitted as early as possible.

Committee for Arts and Hobby Exhibits:

Mrs. Charles H. Williams, *Chairman*
Mrs. George H. Yeager, *Chairman, Judging*
Mrs. Kurt Lederer
Mrs. Marvin I. Mones



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

The Master's Two-Step Exercise Tolerance Electrocardiographic Test: *Part I*

LUIS F. GONZALEZ, MD
Baltimore

Multiple studies have been conducted throughout the years in an attempt to correlate stress tests and myocardial reserve. The response to adrenalin, pitressin, and anoxemia have been described. A primary difficulty in several of these studies is the fact that invariably, modifications of the Master's test are what is actually compared to other stress tests. At times what is reported is the pulse rate, and the blood pressure determination prior to, immediately, and two minutes after the completion of an amount of exercise which may or may not be as recorded in Master's original tables. Other investigators have allowed the individuals being tested to perform the required number of steps (as described in Master's original tables) without any specific time limitation. As described by Master, a single exercise test is to be completed in 1½ minutes and a double exercise test in 3 minutes. Some require that the person being tested carry out as many steps as possible within the prescribed period of time, or to exhaustion. Still others insist that the person being tested carry certain amounts of weight during the exercise test. Also, a lack of uniformity has been noted in the type, height, and number of steps involved. At times, chairs are used in place of the steps described earlier.

In 1935 Dr. Arthur M. Master presented the results of 1,000 tests carried out on 210 men and 234 women who had been exercised over 9in. steps, a total of 1½ ft in height, over 1½ minutes in time. Blood pressure, pulse and respirations were measured. From the data collected and the individuals' weight, the work performed in ft—lbs per minute was calculated.

The formula used included the number of ascents multiplied by the individual's weight in lbs, multiplied by 1½ ft (height of the steps); all of these divided by 1½ minutes. The formula cancels the 1½ units; consequently, work per minute was described in reference to the number of ascents against the weight in lbs. It was found that the systolic blood pressure was the least stable of the factors evaluated, whereas the diastolic blood pressure was the most stable factor. It was eventually suggested that the blood pressure and the pulse rate must return to within 10 points of the base line values 2 minutes post exercise. Finally, Master considered that electrocardiographic changes following the exercise tests were of more practical value than blood pressure and pulse responses.

In 1944 Master published data suggesting that the electrocardiographic abnormalities noted subsequent to the performance of these exercise tests were due to lack of oxygen supply to the heart muscle, and that similar electrocardiographic abnormalities could be reproduced in the same individual by breathing 10% oxygen.

In 1950, Master defined the post-exercise electrocardiographic criteria which (in his opinion) best correlated with the presence of myocardial ischemia. He stated that an ST segment depression of 0.5 mm

or greater, the flattening or inversion of a previously upright T wave, or the production of an upright T wave from a previously flat or negative T (exception in lead 3), premature beats, arrhythmias, intraventricular conduction delays, bundle branch block, large Q waves, first degree heart block, and other types of heart block were considered abnormal responses to exercise.

He pointed out that a positive exercise test is not necessarily a sign of organic coronary disease and that coronary insufficiency may be functional, a point previously raised by Duchosal and Scherf. Nineteen years later, he stated that an abnormal response to an electrocardiographic stress test is no more than circumstantial evidence of the possible presence of silent coronary disease in asymptomatic individuals with normal resting EKGs.

Sokolow exercised his patients until a typical attack of pain occurred or until the patient became tired or dyspneic. An abnormal electrocardiographic response to exercise consisted of ST depression or elevation of 1 mm or more in lead 1; 1.25 mm or more in leads 2 or 3; and 2 mm or more in lead V4. An upright T wave becoming diphasic or inverted in leads 1, 2, or V4, or development of bundle branch block was considered abnormal.

Mattingly and Robb based their criteria on Paul Wood's definition of an ischemic ST segment—a flattened horizontal depression of the ST segment. Such an ischemic depression, greater than 0.5 mm is considered an abnormal response to exercise in the absence of hyperventilation, digitalis, or other drugs that cause electrocardiographic deformities.

A negative response to exercise consisted of no significant electrocardiographic changes, of transitory ST junction depression, or isolated T wave changes. Arrhythmias, conduction abnormalities, ST segment depressions less than 0.5 mm, and prolonged ST junction depression with flattening of the ST segment were considered of doubtful or no significance.

Katz' criteria include ST depression in two or more leads, 0.5 mm or more for limb leads, and 1.5 mm for chest leads; changes in the T waves in leads 1, 2, V4 or V5 becoming indiscernible, diphasic or inverted and the occurrence of ventricular extrasystoles, intraventricular conduction delay, or AV block. Katz has emphasized that delayed positive responses may be completely missed if the study is discontinued too early.

Several of the continuing controversies were brought to light in a series of letters to the Editors in the American Journal of Cardiology in 1964, subsequent to an article entitled "Evaluation Of Some Criteria For The Dynamic And Post-exercise Electrocardiogram In Diagnosing Coronary Insufficiency." These are rather instructive and should be read in detail.

References supplied upon request.

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MRS. FRANK A. FARAINO, EDITOR

Woman's Auxiliary Goes To The Races For Fun(ds) For AMA-ERF

Undaunted by a change of date and somewhat inclement weather, supporters of the American Medical Association Education and Research Foundation gathered at Laurel Race Track on December 3, 1969.

Auxiliary members from Baltimore city, Baltimore County, Cecil County, Four-Counties, Harford County, Prince George's County, and Members-at-Large, their physician-husbands and guests enjoyed a tasty buffet luncheon in Laurel's famous Chesapeake Room with Art Brown of the Laurel staff as their host. Reserved seats in the clubhouse awaited the group who had come to the races in support of the project arranged by the Auxiliary's State Chairman, Mrs. Elmer Linhardt, to raise funds for medical education and research.

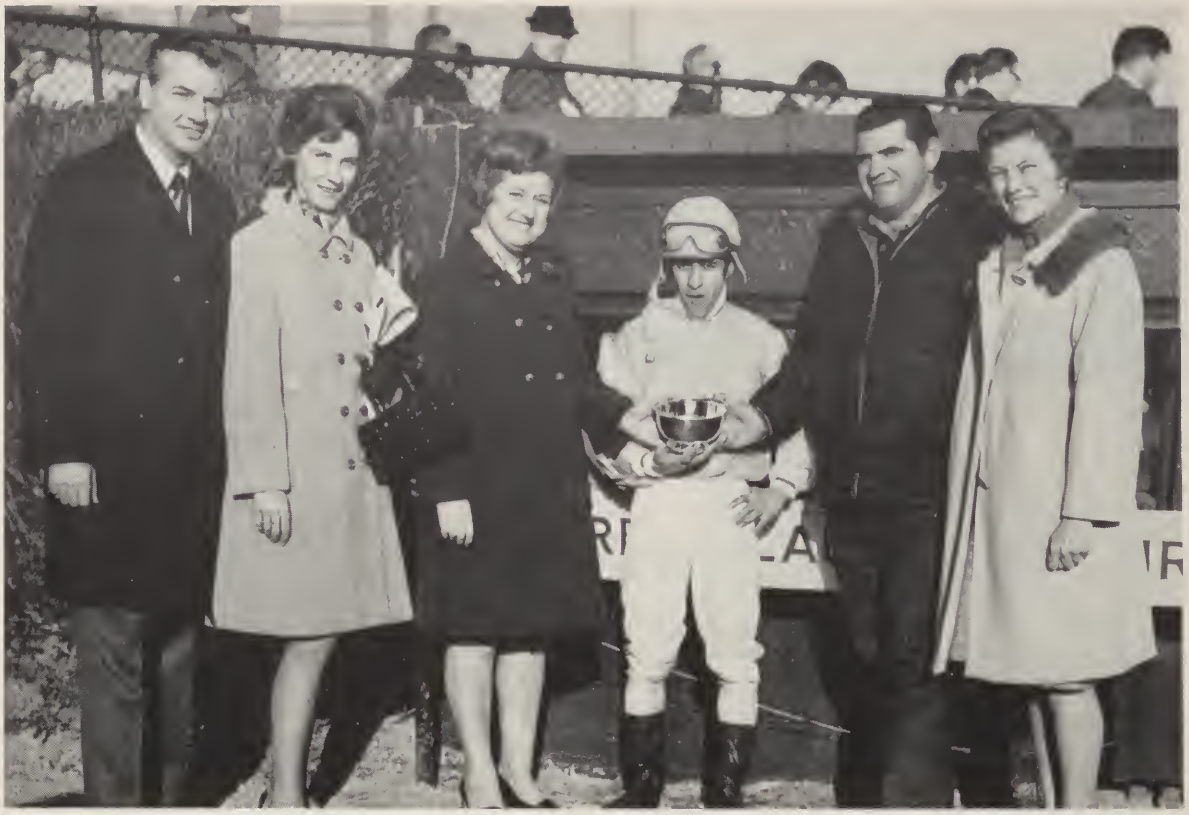
The sixth race was named for the Woman's Auxiliary and, in keeping with tradition, Mrs. Wallace H. Sadowsky, president, formally presented an engraved silver Revere bowl to Mr. and Mrs. Richard C. Smith, owners of "Twisty Clem", winner of the Medical and Chirurgical Faculty Woman's Auxiliary purse. Jockey José Castillo; Trainer Robert W. Anderson; and Mrs. Elmer G. Linhardt were also in the winner's circle to witness the presentation.

All proceeds derived from this project will be forwarded to the national AMA-ERF office and credited to the participating component auxiliaries.

Last year, physicians' wives throughout the nation raised a total of $428,875; the Maryland Auxiliary's contribution was $5,795.18. Under the conscientious leadership of Mrs. Linhardt, other projects of the Auxiliary to raise funds for AMA-ERF are the sale of Christmas cards, collection of S&H Green Stamp books, and sale of memorial, appreciation, congratulatory, and get-well cards.

Funds raised by the medical auxiliaries support two branches of the American Medical Association Education and Research Foundation. They are: (1) Funds for Medical Schools (unrestricted), and (2) Student Loan Fund. All funds raised go to the Foundation since the AMA absorbs the administrative costs. Funds for the medical schools help solve the financial problems facing every medical school dean in the country. In the past, this unrestricted money has been used by college deans to expand their faculties, increase faculty salaries, make building improvements, and purchase needed laboratory equipment and library books.

Funds designated for the Student Loan Program will enable many students to complete their medical education and will encourage others to enter medical schools. A medical student, intern, or resident may borrow a maximum of $1,500 in any 12-month period, $10,000 in a seven-year period, but may not exceed $15,000 total accumulated loans. Loan repayment may be spread over a ten-year period. Application blanks and pertinent details are available at each medical school and hospital administrator's office.



Photographed following the triumphant win by "Twisty Clem" at Laurel on December 3, 1969 were: (from left to right) **Mr. and Mrs. Richard C. Smith, proud-as-punch owners of "Twisty Clem"; Mrs. Wallace H. Sadowsky, president of the Woman's Auxiliary, who presented the trophy to the winner of the Medical and Chirurgical Faculty Woman's Auxiliary purse; jockey José Castillo; trainer Robert W. Anderson; and Mrs. Elmer G. Linhardt, the auxiliary's AMA-ERF State chairman.**

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PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
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library

Professional Conferences

Since our last real communication in the JOURNAL this library has participated in several professional conferences in the region.

One special meeting at the National Library of Medicine involved preparations for the compilation of a union list of serials holdings in the major medical libraries of the Mid-Atlantic area, which includes states from Maryland to North Carolina. No specific action has been accomplished on this project to date.

Another meeting was the annual Regional Medical Library Association meeting in Bethesda, with the National Institutes of Health and National Library of Medicine as hosts. The program centered around the plans and accomplishments of the regional medical libraries in the U.S. News reports were given for Maryland by your librarian; from Virginia by Dr. Wilhelm Mohl of the University of Virginia Medical School Library; and by Mrs. Jean Jones, American Psychiatric Association Library, from the Washington area. Miss Hilda Moore, librarian from the University of Maryland Health Sciences Library, on behalf of her library, the Med/Chi Library and the medical libraries of the Baltimore metropolitan area, invited the group to meet with us in the fall of 1970—probably in October.

The national convention of the Medical Library Association, having postponed its spring meeting on account of the International Congress on Medical Librarianship in Amsterdam, met in Louisville late in October. Attendance there was very good. Baltimore was represented by 15 members. Meetings were generally well planned, particularly those set up by the Louisville librarians and the arrangements committees.

The Medical Society Group meeting proved one of the best group meetings, with Dr. Walter Hume, Jr., of Louisville, speaking as president of the Jefferson County (Ky.) Medical Society, and our own consultant, Mr. Lee Ash, speaking on his favorite subjects—rare book and history of medicine collections he has surveyed. Needless to say, our Med/Chi survey was prominent in his comments. As chairman, I was pleased that it proved to be a lively and interesting affair.

The last conference, in which a number of Baltimore librarians and at least one Med/Chi member figured, was the Tri-State meeting composed of Maryland, Delaware, and D.C. Hospital Associations representatives. For the second year, the Baltimore Hospital Librarians Association sponsored an all-day meeting for discussion of hospital related libraries and their function in the hospitals. Both meetings were very successful and attendance was good. Dr. Brannon T. Hubbard, member of the Medical Faculty of Maryland, was the speaker on services the hospital physicians and surgeons expect from their libraries. Other speakers were from the nursing organizations and other hospital fields.

Now we look forward to 1970 and the beginning of a new decade in medicine and the medical library profession.

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Allgire, Mildred J.
Nurses can give and teach rehabilitation. New York, Springer Pub. Co., 1968.

American Hospital Association.
Readings in disaster planning for hospitals. Chicago, 1966.

Anderson, Carl Leonard.
Community health. St. Louis, C. V. Mosby Co., 1969.

Antia, Framroz Pirojshaw.
Clinical dietetics and nutrition. New York, Oxford U.P., 1966.

Arthritis Foundation.
Home care programs in arthritis. New York, The Arthritis Foundation, 1969.

Axline, Virginia Mae.
Play therapy. New York, Ballantine Books, 1969.

Breckinridge, Elizabeth Llewellyn.
Effective use of older workers. Chicago, Wilcox and Follett Co., 1953.

Buss, Arnold Herbert.
Theories of schizophrenia. New York, Atherton Press, 1969.

Conference on Aging. 4th, University of Michigan, 1951.
Rehabilitation of the older worker. Ann Arbor, University of Michigan Press, 1953.

Conference on the Chemotherapy of Burkitt's Tumor, Kampala, Uganda, 1966.
Treatment of Burkitt's Tumor. New York, Springer, 1967.

Cooley, Denton A.
Surgical treatment of congenital heart disease. Philadelphia, Lea & Febiger, 1966.

Cooper, Kenneth H.
Aerobics. New York, Grosset & Dunlap (Bantam Books), 1968.

Dally, Peter.
Chemotherapy of psychiatric disorders. New York, Plenum Press, 1967.

Emmett, John L.
Clinical urography. Philadelphia, W. B. Saunders, 1967.

Frankl, Viktor Emil.
The will to meaning. New York, World Pub. Co. 1969.

Fletcher, Gilbert Hungerford.
The head and neck. Chicago, Year Book Medical Publishers, 1968.

Gerarde, Horace W.
Toxicology and biochemistry of aromatic hydrocarbons. Amsterdam, New York, Elsevier Pub. Co., 1960.

Glenn, James F.
Urologic surgery. New York, Harper & Row, 1968.

The Guide to summer camps and summer schools. 15th edition, Boston, P. Sargent.

Harrison, M. Spencer.
Meniere's disease. Springfield, Ill., C. C. Thomas, 1968.

Hughes, Helena Everard.
Handbook of diagnostic cytology. Baltimore, Williams and Wilkins, 1968.

Human influenza: aspects of the immune response to vaccination. Bethesda, National Institutes of Health, 1969.

Inglis, Brian.
A history of medicine. Cleveland, World Pub. Co., 1965.

Institute on new developments in the rehabilitation of the narcotic addict. Fort Worth, Tex., 1966. Washington, Vocational Rehabilitation Administration, 1967.

International Symposium on Enzymatic Aspects of Metabolic Regulation. Mexico, 1966. Bethesda, Maryland, U.S. National Cancer Institute.

Intracranial aneurysms and subarachnoid hemorrhage. Edited by Adolph L. Sahs, Philadelphia, Lippincott, 1969.

Jackson, Robert L., 1967.
A history of Provident Hospital. Baltimore, Md. New York, National Medical Association, 1967.

Kadushin, Charles.
Why people go to psychiatrists. New York, Atherton Press, 1969.

Lindeboom, Gerrit Arie.
Herman Boerhaave. London, Methuen, 1968.

Lorand, Arnold.
Old age deferred. Philadelphia, F. A. Davis Company, 1925.

Lynch, Henry T.
International directory of genetic services. 2d ed. New York, National Foundation March of Dimes, 1969.

McCombs, Robert Pratt.
Fundamentals of internal medicine. Chicago, Year Book Medical Publishers, 1969.

Maryland Medical Service.
Adolescence for adults. Chicago, The Blue Cross Association, 1969.

Medical Society Executive Conference, San Francisco, 1958.
Personnel practice survey. Chicago, Turiel and Associates, Inc., 1959.

Medical investigation of aviation accidents. Chicago, College of American Pathologists, 1968.

Mullan, D.
Studies in clinical enzymology. St. Louis, Mosby & Co., 1969.

Oakley, Wilfrid George.
Clinical diabetes and its biochemical basis. Oxford, Edinburgh, Blackwell Scientific, 1968.

Oxorn, Harry.
Human Labor and Birth. New York, Appleton-Century-Crofts, 1968.

Richmond, Julius B.
Currents in American medicine. Cambridge, Harvard University Press, 1969.

Robertson, Alexander White.
Studies in electro-pathology. London, G. Routledge & Sons, Ltd., 1918.

Rodman, Theodore.
Pulmonary emphysema and related lung diseases. St. Louis, C. V. Mosby Co., 1969.

Saward, Ernest W.
The relevance of prepaid group practice to the effective delivery of health services. U.S. Public Health Service, 1969.

Scarpelli, Emile M.
The surfactant system of the lung. Philadelphia, Lea & Febiger, 1968.

Schwarz, Richard H.
Septic Abortion. Philadelphia, Lippincott, 1968.

Sebrell, William Henry.
The vitamins; chemistry, physiology, pathology, methods. New York, Academic Press, 1967.

Shave, David W.
The language of the transference. Boston, Little, Brown, 1968.

Tidy, Noel M.
Massage and remedial exercises in medical and surgical conditions. Baltimore, Williams & Wilkins, 1968.

U. S. Dept. of Health, Education and Welfare. Library.
Community planning for health, education and welfare. Washington, U. S. Bureau of Family Services, 1967.

U. S. National Heart Institute.
National blood resource program. Bethesda, National Institutes of Health, 1969.

U. S. Public Health Service.
Diabetes source book. Washington, U.S. Public Health Service, 1968.

U. S. Public Health Service Cooperative Study.
Renal disease and hypertension. Boston, Massachusetts.

Urinary tract infection. Edited by Francis O'Grady and William Brumfitt.
London, New York, Oxford U. Press, 1968.

Warner, Marie Pichel.
Modern fertility guide. New York, Funk & Wagnalls, 1969.

Watson, William L.
Lung cancer. St. Louis, C. V. Mosby Co., 1968.

Weiser, Russell S.
Fundamentals of immunology for students of medicine and related sciences. Philadelphia, Lea & Febiger, 1969.

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Maryland State department of mental hygiene

Length of Hospitalization

More than 40% of the 11,997 patients admitted to Maryland's state-operated psychiatric hospitals during the 1968 fiscal year were discharged within one month after onset of hospitalization. Within half a year this figure reached nearly 70% with a major proportion of the remainder released from the hospital on long-term leave preparatory to ultimate discharge. The average period of hospitalization declined from six months in 1963 to six weeks in 1968. At the same time, the decrease in the proportion of geriatric admissions and the early release of most other patients produced a steady decline from 8.2 in 1948 to 2.9 in 1968 in the percentage dying in the hospital within the first six months after admission.

	YEAR ADMITTED			
	1968	1963	1958	1948
NUMBER ADMITTED	11,997	7,257	4,145	2,100
STATUS AFTER 6 MONTHS (%)				
DISCHARGED	69.4	50.0	30.2	14.6
LESS THAN 1 MONTH	41.0	21.6	11.1	7.8
1-5 MONTHS	28.4	28.4	19.1	6.8
DECEASED	2.9	4.8	6.0	8.2
UNDER HOSPITAL SUPERVISION *	27.7	45.2	63.8	77.2

*** In hospital and on long-term leave**

A number of factors relate to this continuing reduction in average length of hospitalization. Within the hospitals, rising employee-patient ratios, the current emphasis on drug therapy, other new treatment techniques and modalities have played an important role. In the community, a continuing increase in the number and variety of available supportive services has enabled hospitals to release patients earlier. At the same time, as illustrated by the following data, admissions are gradually shifting from those requiring extended services for chronic illnesses to those admitted for short-term intensive treatment of acute disturbances.

1. The proportion of voluntary admissions is increasing in each hospital and, to a lesser extent, among many diagnostic categories of patients. Last year, 36.8% of the 11,997 patients entering these facilities were self-admitted. This percentage was 31.1 of the 7,257 admitted in 1963.

2. The proportion of admissions with a diagnosis of schizophrenia or other psychotic disorders declined from 31.9% in 1963 to 17.3% in 1968. During the same time period, the proportion of all admissions for the treatment of alcoholism increased from 30.2% to 49.2%. Most alcoholics are released after a brief hospitalization.

3. The average age of admissions is decreasing in many diagnostic groups. Admissions now occur more frequently during earlier, more acute phases.

Latest available data indicate that admissions are at a record level and, if present trends continue, will rise 10% or more per year. Development of a coordinated program involving presently existing facilities and the expansion of community centered residential and outpatient services is essential to meet this rising need.

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative derma

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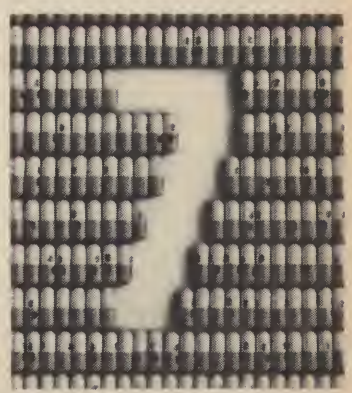
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...ti, Stevens-Johnson syndrome, ...Ll's syndrome (toxic necrotizing e...lermolysis), or a generalized a...rgic reaction similar to serum s...tness may occur and require p...manent withdrawal of medica...t... Agranulocytosis can occur s...denly in spite of regular, repeated n...mal white counts. Stomatitis a... rarely, salivary gland enlarge...m...t may require cessation of treat...m...t. Such patients should not re...ive subsequent courses of the d...g. Vomiting, vertigo and languor m... occur. Leukemia and leukemoid re...tions have been reported. While n...definitely attributable to the d..., a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria, glomerulonephritis and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

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Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Highlights

Medical Assistance—Changing Trends in Appeals for Fair Hearings

So much has been heard about the financial problems encountered with Medical Assistance that some attention to the human aspects of this experience seems well overdue. Small notice has been taken of the many individuals and families saved from despair and restored to healthy and independent living because needed medical care was provided. Likewise, there seems to be little awareness of the strain, stress, and hopelessness experienced by many who do not quite meet the program's restrictive and inflexible eligibility standards, yet cannot possibly afford the medical care which they need.

Title XIX of the Social Security Act requires that a fair hearing be granted to any individual who requests one because his claim for Medical Assistance is denied, or because he is aggrieved by any action of the agency which affects his receipt of Medical Assistance. The receiving of appeals and the conducting of the hearings gives, at least, a small view of the human problems. It is recognized that this view represents no more than a portion of the problem, and that the most discouraged individuals are the least likely to file an appeal.

Since the beginning of the Maryland Medical Assistance Program in 1966, the vast majority of appeals has been related to financial eligibility. Since most of the persons who are obliged to depend on public assistance for maintenance are automatically certified for Medical Assistance, those who appeal are the "medically indigent". Approximately half of the appellants have an earned income, while the other half live on old age, survivors, and disability benefits and small pensions or both. It has been observed that the position of those with fixed, marginal incomes, or seasonal employment is especially difficult.

A continuing problem for which no satisfactory solution has been found involves patients who live at home, but require continuous medical care on an outpatient basis. Many of these have incomes which are somewhat above the state eligibility scale, but are insufficient to pay for periodic visits to the physician's office or clinic, for laboratory tests as recommended, and for medications as prescribed. The incidence of chronic disease is high in this group, yet such patients avoid going to the physician when they cannot pay for the service; and similarly, they often leave prescriptions unfilled. We have known patients in this group to have such diagnosed conditions as emphysema, cardiovascular disease, diabetes (severe), rheumatoid arthritis, lupus erythematosus and hypertension. Sometimes the physicians treating the patients have provided notes indicating the severity of the disease. Too little medical information is available on these patients to make an accurate statistical study, but it seems that cases of this kind are increasing in number.

The past six months have shown a conspicuous new trend in the appeals which the State Department of Health receives. While those appeals related to financial eligibility are still in the majority, there is a rapid increase of appeals related to the level of nursing home care which will meet the patient's needs. Early in 1969, the federal policy for Medical Assistance tightened the requirements for standards of care to be met by "skilled nursing homes". At the same time, it clarified the definitions and guidelines for determining the level of care needed by individual patients. Medical Assistance coverage is available when care is given in a "skilled nursing home" facility and only for patients certified to receive that level of care.

An increasing number of appeals now are on behalf of patients who are considered by their families to need skilled nursing care but, according to a careful review and assessment made by the local health department medical authority, need care at an intermediate level instead. These situations pose several problems for the patients, their families, and for the

local health department as well. In many instances, the patients are already in skilled nursing homes, but no longer need the full day's care given by professional nurses. Typically, the family is reluctant to have the patient moved because they question the patient's ability to adapt to another change. In addition, they fear that the lower level of care will not be adequate. An additional factor is that Medical Assistance cannot pay for the intermediate levels of care. The more stringent means test for public assistance under the Department of Social Services cannot always be met by the patient and family, thus leaving no source of help in financing the care. It has become apparent that a number of adults, often with families of their own, gave devoted care and financial support to a parent at home before that parent required admission to an institution. However, they cannot meet today's cost of the institutional care for an indefinite period without drastically limiting their own scale of living and educational or other plans for their children.

At this stage of experience with the Medical Assistance Program, it is possible to identify some of the gaps and other problems as they affect the individuals and families who have medical problems requiring care which they cannot always afford or obtain. Fortunately, some progress is being made. Some well-qualified nursing homes are establishing areas within their institutions which provide higher level (Intermediate A) nursing care for such patients. This avoids moving many patients; but for those who are not eligible for public assistance, the financial problem still exists. The number of beds for intermediate care is still small when compared to the large and growing need for such nursing facilities. It is hoped that some solution can be found for those patients at home whose need for medical care cannot be met either by themselves or by Medical Assistance. Many of these represent a high risk group with a considerable potential for hospitalization, since they do not get the care which could prevent hospitalization.

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Diphtheria, Tetanus, and Pertussis Vaccine

Routine immunization to prevent diphtheria, tetanus, and pertussis has been widely practiced in the United States for the past 20 years and has resulted in a marked decline in the incidence of these diseases. However, small outbreaks of diphtheria associated with high mortality rates continue to appear in inadequately immunized individuals of all ages. Tetanus is also an important health problem. Since the organism can be found anywhere, there is a need for every person to receive primary immunization and periodic booster doses. Pertussis, on the other hand, is primarily a disease of infancy and thus requires immunization with diphtheria and tetanus toxoids and pertussis vaccine (DTP) early in life.

The preparations used for immunization against diphtheria, tetanus, and pertussis are as follows:

1) Diphtheria and tetanus toxoids and pertussis vaccine (DTP), used *only* for children under seven years of age.
2) Tetanus and diphtheria toxoids, *adult type* (Td). This is the agent of choice for immunization of individuals seven years old and older.
3) Tetanus toxoid (T).

The Medical and Chirurgical Faculty of Maryland concurs with the following recommendations of the Maryland State Department of Health for immunization against diphtheria, tetanus, and pertussis.

I. Primary Immunization

A. Children two months through six years of age:
DTP—(Start at two months or as soon thereafter as possible). Three injections at four to six week intervals with a reinforcing dose about one year after the third dose.

B. Adults and children seven years of age and older:
Td (adult type)—two injections at four to six week intervals with a reinforcing dose one year after the second dose.

II. Booster Immunization

A. Children younger than seven years:
DTP—one dose given between three and six years of age.

B. Individuals seven years old and older:
Td—one dose every ten years (see below for wound management).

III. Tetanus Prophylaxis in Wound Management

Tetanus prevention is important in the treatment of wounds. An adequate history of tetanus immunization should be obtained, and toxoid should be administered according to the nature of the wound and the patient's history. In general, if a person has a wound and

A. If the patient has completed his primary series with three or more shots of tetanus toxoid, Td, or DTP and has had a booster dose less than one year prior to the injury, no additional boosters are necessary.

B. If, however, more than one year has passed since the last shot and the patient has received a complete primary series, then a single dose of Td should be given. (*Only if there is reason to suspect hypersensitivity to the diphtheria component should one substitute tetanus toxoid (T) for Td, adult type.)*

C. If an individual has received incomplete primary immunization, then complete primary immunization as recommended above.

D. If the patient has no history of primary immunization, the decision to use passive immunization will be based on the type and severity of the wound, the extent of contamination, and the time elapsed between injury and medical attention. Passive immunization consists of a single dose (250 units) of Tetanus Immune Globulin (*human*). This is the antitoxin of preference and is far superior to the old type horse serum antitoxin as it has the advantage of longer protection and freedom from severe anaphylactic reaction. When Tetanus Immune Globulin is unavailable, it may be necessary to use the horse or bovine antitoxin. Before either of these animal sera are used, the patient must be carefully tested for serum sensitivity. At the time the tetanus antitoxin dose is given, an initial dose of Td should be administered at a different site and in a separate syringe. The primary series of Td should then be completed.

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Lung Cancer in Women

In comparing the characteristics of lung cancer in men and women, it was found that although the condition is rarer in women than in men, in women it is less frequently resectable at the time of diagnosis and the prognosis is therefore less favorable.

In an effort to understand the differences in lung cancer in men and women, a study was made of clinical, histological, and biological features of tumors in 83 women as compared with 1,353 lung cancers in men, a ratio of men to women of 16:1. The study covered a 15-year period and was carried out at Morriston Hospital, Swansea, Wales.

Histology

Tissue for histological examination was obtained from 56 patients by bronchial biopsy or open operation. Five types of lung cancer were recognized. They were classified as squamous carcinoma, well and poorly differentiated; adenocarcinoma, well and poorly differentiated; and undifferentiated carcinoma. Thirteen of the tumors were squamous cell; 16 glandular; and 27 undifferentiated.

In comparison with some other surveys, the proportion of squamous-type tumors in this series was significantly low and the incidence of glandular and undifferentiated carcinomas was high. The relatively small number of cases of squamous-celled carcinoma may be attributed to the lower frequency of chronic irritation in the bronchi of women than in men, whether due to cigarette smoking or to chronic bronchial inflammation in the latter.

At the time the cancer was diagnosed, the mean age of the women was 56 years, approximately two years lower than that of the men who sought medical advice for a cough. The mean age of men whose cancer was diagnosed as a result of a routine chest X-ray was 61 years. The younger age at diagnosis in women than in men is somewhat surprising since there are more women than men in the older age groups. Since the incidence of lung cancer increases with age, a relatively higher average might be expected in women than in men.

However, a greater proportion of ill-differentiated cancers are found in women than in men. These lesions tend to occur at an earlier age than the differentiated type, thus the age difference may be due to such a factor. Or, the frequency of lung cancer in younger women may be linked to the fact that cigarette smoking is more common in younger than in older women.

Symptoms

Cough, dyspnea, chest pain, and hemoptysis are the principal symptoms of lung cancer. In the series reported, cough was the major symptom at the time of diagnosis in the greatest number of women and men; men complained of dyspnea more frequently than women; chest pain was a common symptom in about the same percentage of men and women. Hemoptysis was more common in men than in women.

Shortness of breath in patients with lung cancer is often the result of a relatively small decrease in respiratory capacity in a person who has respiratory impairment due to chronic bronchitis or emphysema. Since such conditions are less common in women than in men, the lower prevalence of dyspnea in women may be related to the women's general respiratory health.

Metastases

Extrathoracic metastases were detectable at the time of diagnosis in a significant number of women; 18 of the 56 patients in whom histological confirmation of diagnosis was available had extrathoracic secondary deposits.

David J. B. Ashley, MD, and H. Duncan Davies, MD. *Thorax,* July, 1969 (Vol. 24, No. 4).

Lesions were resected in 11 patients, a lower proportion than in the series of men, 13.4% in contrast to 21%.

Of 56 women whose smoking history was available, 23 (41%) were nonsmokers. The mean age of the smokers was 55 years, slightly lower than that of the nonsmokers, which was 57 years. No significant differences were observed in the distribution of histological types of tumors among smokers and nonsmokers.

On the basis of the data obtained, it appears that lung cancer is less common in women than in men, is less likely to be of the squamous-celled type, and is more likely to be of the glandular type or to be undifferentiated. The degree of differentiation is less in women than in men. Lung cancer is likely to occur at an earlier age in women, and extrathoracic metastases are likely to have taken place when symptoms appear. The prognosis of lung cancer in women is worse than in men.

The difference in resectability of lung cancer in men and women cannot be explained on the basis of the histological type of tumor or on the anatomical localization in the bronchial tree, nor can the higher proportion of women patients in this series in whom extrathoracic metastases were present at the time of diagnosis be explained on the basis of the histological type of lesion. An alternative hypothesis is suggested.

Hypothesis

At least one of the genes in the immunological defense mechanism of the body is carried in the X chromosome; mutation at this locus leads to the clinical condition of agammaglobulinemia in which there is a deficiency of a circulating immunoglobulin and also a deficiency of plasma-cell reaction to foreign antigens. With their double complement of X chromosome, women have a lower frequency of agammaglobulinemia and, by inference, a better immunological capacity.

It is suggested that those tumors of the lung which become clinically apparent are the ones in which the multiplying neoplastic cells are able to overcome the immunological defenses of the body which would otherwise treat them as foreign cells and destroy them. In women, with a better defense mechanism, fewer tumors would overcome the defenses, but those which did would be intrinsically more malignant and less amenable to therapy.

This hypothesis would account for the lower proportion of lung cancers in women, which cannot be completely explained by the lower proportion of women who are cigarette smokers. It would account for the reduced frequency with which the tumors are resectable, for the higher proportion of neoplasms of histologically undifferentiated type, and for the generally poorer prognosis in lung cancer in women.



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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
health department

The Reverend Hanna Appointed Coordinator for Drug Abuse Programs

The Reverend Frederick J. Hanna has been appointed Coordinator for Drug Abuse Programs in the Baltimore City Health Department. This new and much needed City Health Department post, authorized by the City Civil Service Commission and the Board of Estimates with the approval of the Mayor, should greatly aid in the city's attack on the problems of drug abuse and the drug abuser.

Mr. Hanna, Chairman of the Baltimore Commission to Study Drug Addiction, has been close to Baltimore's drug and social problems for many years, not only as Minister of Social Services of Emmanuel Church, but also as the former Director of the church's Crisis Center, an experimental ministry supported by 11 downtown churches, which provides direct assistance to city residents when community resources are lacking. As Director of the Center, Mr. Hanna has devoted much time to the study of drug abuse among young people and has dealt with many individuals who are either addicted to drugs or are abusing them.

As Coordinator for Drug Abuse Programs in the City Health Department, Mr. Hanna will continue his efforts to develop community awareness of the extent of the drug abuse problem and encourage the development and expansion of comprehensive educational programs. Moreover, Mr. Hanna will coordinate and promote treatment and rehabilitation programs for drug abusers in the city, develop in-service training programs for professionals, and seek to prevent emotionally disturbed young people from turning to drugs.

According to Mr. Hanna, there is a "tremendous need for straight information about drugs and for honest facts." Mr. Hanna believes that if we do give information in a straightforward way and "level" with our young people, the great majority will make the right decision.

Recognizing the need for scientific research and additional programs for treatment and post-treatment care, Mr. Hanna feels that the greatest emphasis should be placed on finding effective ways to prevent the drug problem through strengthening the individual, his family, and the educational curriculum.

Born in Baltimore, Mr. Hanna attended the public schools of the city and received the BS degree from The Johns Hopkins University. Following attendance at Bexley Hall Divinity School of Kenyon College in Ohio, he was ordained deacon in 1956 and priest in 1957. He has been Vicar of the Chapel of the Redemption at Locust Point in Baltimore, Assistant Rector of Emmanuel Church, and currently serves as an Associate on the staff of Emmanuel.

During 1963 and 1964, Mr. Hanna attended St. Augustine's College in Canterbury, England, where he studied social services and church-state relationships and prepared a thesis on the "Role of the Church in Urbanized Society." His visit not only enabled him to meet with city planners, social scientists, and community workers, but also permitted him to do special work in the areas of drug abuse and homosexuality.

Mr. Hanna is a member of the Baltimore City Community Relations Commission, is Secretary-Treasurer of the Board of Metropolitan Strategy and Christian Social Relations, and serves on the boards of many community agencies including the Baltimore Area Council on Alcoholism, the Pilot House, the Prisoners Aid Association of Maryland, and the Metropolitan Senior Citizens Center.

Physicians who have patients with drug addiction problems may call Mr. Hanna at 837-2710, extension 31. Mr. Hanna's office is in the Western Health District Building, 700 W. Lombard Street.

Amendment to Vital Records Regulations

An amendment to Regulation 43M01 governing Vital Records was approved by the Attorney General and subsequently adopted by the Secretary of Health and Mental Hygiene on October 31, 1969. This amendment relating to the registration of Fetal Deaths in Maryland became effective January 1, 1970 and reads as follows: *030102 If the gestation period is unknown but the fetus weighs 500 grams or more a fetal death certificate must be filed.*

The amendment changes the previous requirement that if the period of gestation is unknown and the fetus weighs 400 or more grams a fetal death certificate must be filed. As of January 1, 1970 the requirement for registering a fetal death is:

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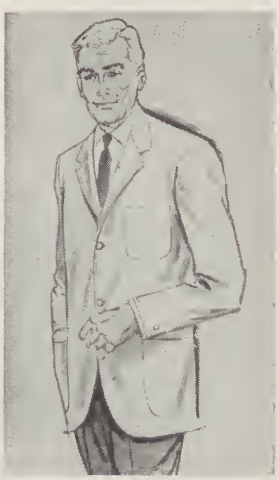
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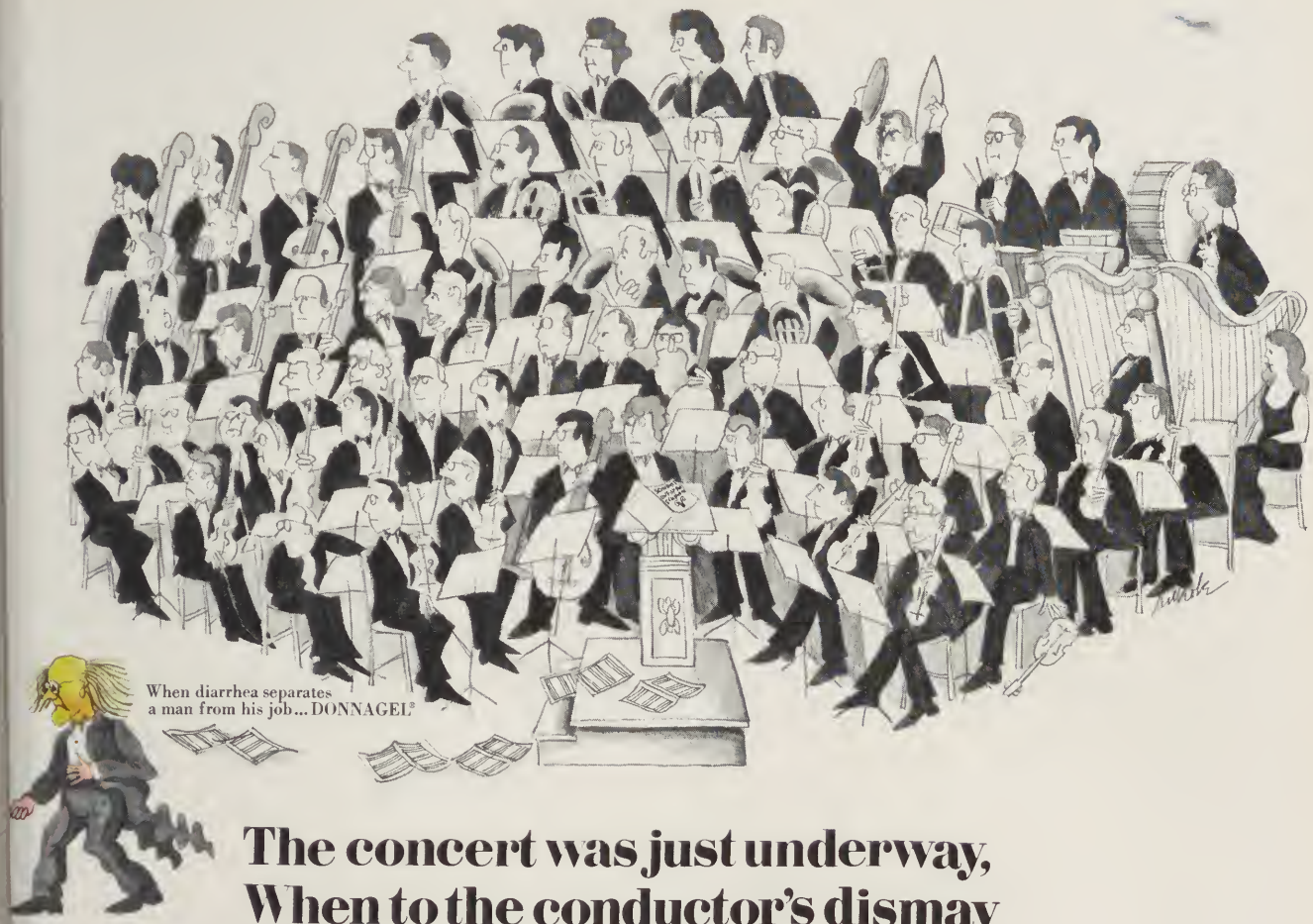


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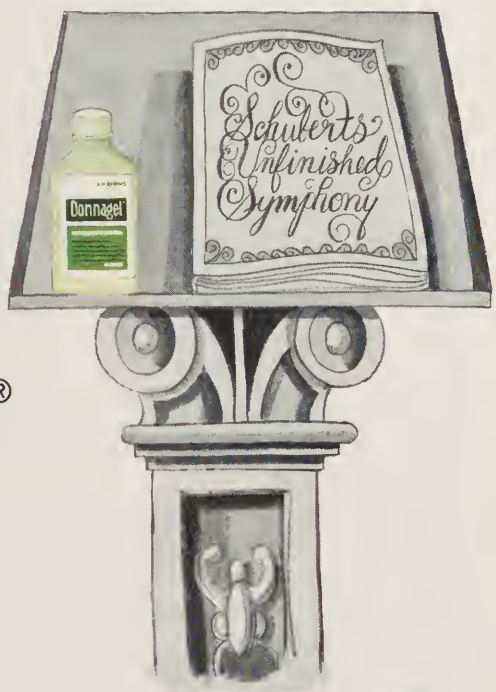
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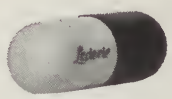
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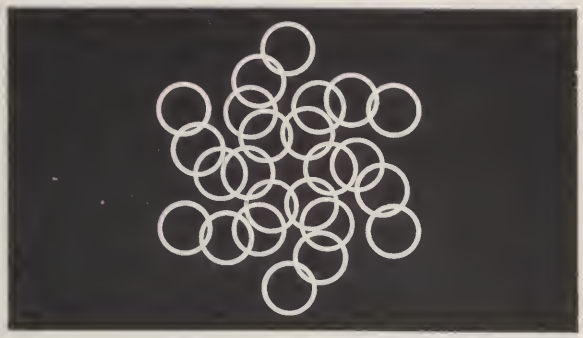


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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

Nursing Care for the Alcoholic

ELLEN A. ANDRUZZI, RN
Chief, Mental Health Nursing
District of Columbia Department of Public Health
Washington, D.C.

From the behavioral point of view, an alcoholic—that person whose drinking seriously interferes with his health, interpersonal relationships, and occupational status—is an extremely dependent person with great oral needs. Some of us satisfy such needs by smoking; others by overeating. Nurses are nurturing persons with strong parental impulses. They can be very helpful to an alcoholic if they understand what to do and how to do it.

Eric Berne defines alcoholism as a game, one of those "games people play." The players are: It, Persecutor, Patsy, Connection, and Rescuer. Each player perpetuates the game. The alcoholic is It and the nurse can play any of the other roles, if she is not careful. Instead of playing a role, the nurse can respond with firm, matter-of-fact parenting. The nurse who is alert and consistent in her treatment of the patient can avoid being manipulated. If the nurse's only visible function is to administer medication, she is the Connection. If she is the staff member who reacts with hostility and punishment to the patient's provocative behavior, she is the Persecutor. If she is the one who always exhibits great faith in the patient's expressed intention to reform and couldn't possibly believe he is drinking in the hospital, she's a Patsy. If she commiserates with the patient because "no one understands" him, makes personal sacrifices to get cigarettes for him, and generally defends him against Persecutors, she is a Rescuer. Let us examine the types of situations where you might have alcoholics as patients.

How many of you work in places which admit persons who are acutely intoxicated? They may be admitted with a diagnosis other than alcoholism because the hospital has a policy not to admit alcoholics. Alcohol oxidizes and is excreted in 24 to 72 hours, depending on such factors as the amount of alcohol ingested, and the size and physical condition of the person. Ordinarily, a safe, clean environment in which the patient can "sleep it off" will suffice. Some physicians will order a tranquilizer or a mild sedative. When the patient is able to tolerate food, he needs a high-caloric, high-vitamin diet. This may require some firm, good natured encouragement by the nurse.

The alcoholic with acute psychosis (either delirium tremens or alcoholic hallucinosis) is a medical-mental health emergency. As with the person who is acutely intoxicated, the nurse must be alert for the signs and symptoms of injury and complications. Fractures and lacerations are the most frequently noted injuries. Skull fractures can result in soft tissue damage, so the nurse must watch for the signs of increased intracranial pressure—a strong bounding pulse, increased blood pressure, and increased temperature. Esophageal varices, one of the complications of Laennec's cirrhosis, can rupture and lead to a fatal hemorrhage. Lobar pneumonia is another serious complication. A patient suffering from delirium tremens and alcoholic

Presented at the Symposium on Alcoholism for Nurses, held at the Richmond Academy of Medicine, Richmond, Virginia, on April 10, 1969.

hallucinosis is frequently extremely frightened. In DTs, the patient has visual hallucinations of insects, and small or oddly colored animals or both. The patient with hallucinosis has auditory hallucinations, usually accusatory or disparaging. He responds defensively and angrily. As the diagnostic name implies, a patient with DTs has uncontrollable tremors.

Nursing care involves carrying out medical orders for giving mild tranquilizers and for improving nutrition. Vital signs are taken frequently and the intake of fluids is encouraged. If the history and physical examination of the patient reveal coexisting conditions, the nurse provides the appropriate care. The nurse on the medical-surgical unit may have a patient who has been admitted for an acute febrile illness or for surgery following an injury, who goes into DTs. If the syndrome is not recognized and adequately treated, results can be serious and even fatal.

In all settings, the alcoholic patient needs a nurse who is as understanding and nonpunitive toward him as she would be toward a nonalcoholic patient. The nurse must promote the patient's safety and reassure him as often as needed. If the patient has reached the point where he is oriented and less confused, the nurse must support and encourage him as he gives up his relatively satisfying rationalizations and his use of alcohol as an escape from pain, and strives to learn new ways to cope with problems. If the facility has an active treatment program, the nurse participates actively on the treatment team. She screens and admits the patient, participates in the diagnostic, treatment, and planning conference, and then may have him in a therapy group. The nurse may also participate in family therapy and counseling. The nurse may encourage the patient to attend Alcoholics Anonymous meetings held in the facility, as well as make sure that he attends scheduled sessions of occupational therapy, manual arts therapy, work therapy, and vocational training. If the patient needs help with shelter and income, the nurse makes sure the patient keeps appointments with the social worker who can assist him. If the facility has no treatment program, the nurse encourages the patient to accept a referral to an outpatient clinic or asks a member of AA to talk with him about participating in that organization.

The patient in such Alcohol Rehabilitation Centers may have been in the custody of the sheriff, local police, or a state hospital before admission. In a few areas, he will have been in a Detoxification Center for one to five days before he is admitted to the Rehabilitation Center. Depending on his prior experience, he is restless, irritable, shaky, and demanding. He may have slept poorly or not at all for several days. When drinking, he has no desire for food, so he may not have eaten a full meal for several days. He is in a state of emotional turmoil. Again, the nurse is alert for physical complications and coexisting conditions. The patient may have pulmonary tuberculosis, and may require periodic chest X-rays. After many years of drinking, the patient may have peripheral neuritis. The nurse exploits the time spent dressing lacerations, burns, and other lesions to establish a healthy relationship with the patient. She meets his suspicions and hostility with attentive listening and brief, clear explanations of policies and procedures and their value to him. She avoids angry retorts and punitive methods so as not to be cast as Persecutor. She communicates freely with members of the nursing and health teams and does all she can to promote consistency in staff response. This kind of positive action helps the nurse avoid playing the roles of Patsy, Connection, and Rescuer. The nurse must be sure that the alcoholic receives the medication and treatment that he needs, and does not talk her into giving him medications that are not essential. She recognizes that he volunteers as a Helper and seeks to take on a pseudo-staff identity in order to exploit the staff as Connections. There is a fine line between his legitimate participation in work therapy or a work release program and his role as exploitative Helper. The nurse must be sure that the former occurs.

In the Rehabilitation Center, selected patients can make up educational deficits, learn a trade, improve known skills, learn manual arts and craft work, or be assigned to a job that produces some income while they are under treatment. The nurse contributes to the health and social skills content of formal classes. She also makes sure that the patient attends other classes or gets to a job regularly, or both. Nurses use the therapeutic community to give the patient an experience in developing a sense of responsibility toward other patients and to enhance his own self-respect. With this type of approach, the patient develops the rules and limits and is responsible for enforcing them. Such patients also divide daily living responsibilities among themselves and select or elect fellow patients to do the necessary follow-through. The therapeutic community gives the dependent alcoholic an opportunity to practice taking care of himself and others. It strengthens his ability to function effectively in the larger community.

As the supervisor at the D. C. Rehabilitation Center for Alcoholics, Mary Herring says, "Nurses working with alcoholic patients should establish realistic goals for themselves and the patients. To maintain sobriety for a period of weeks or months instead of days is an accomplishment even though patients drink again and again. To be able to re-establish a comfortable nurse-patient relationship with a man who feels guilty about drinking episodes requires patience, sometimes more than we have, but a necessary virtue in the rehabilitation of alcoholics."

Many nurses have, or can develop the necessary knowledge and skills to give adequate therapeutic care to the alcoholic patient. In many settings, these nurses may well be the primary mental health workers for this group of patients. It is our choice!



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Orthopedic Aspects of Spinal Cord Injuries

GERHARD SCHMEISSER, JR, MD
Associate Professor of Orthopedic Surgery
The Johns Hopkins University School of Medicine
The University of Maryland School of Medicine
Associate Chief of Surgery
Baltimore City Hospitals

The early treatment of spinal cord injuries should be influenced by the following factors. Neurological deficit from transection of the spinal cord is irreversible. Injury to the spinal cord and nerve roots is usually caused by impingement on components of the vertebral column. Persistent or repetitive impingement may aggravate the injury and increase the permanent neurological loss. Prevention of this additional loss is the primary objective of treatment. The only method of preventing this additional loss is by relieving persisting impingement and preventing re-impingement. This can be done by repositioning or removing portions of the vertebral column (decompression) and immobilizing the injured area (stabilization).

Initial Care

Impingement may be due to different types of disruptions of the vertebral column and its associated structures (Fig. 1). These include extrusion of the nucleus pulposus, infolded edges of torn ligaments, dislocations, and displaced vertebral fragments. Depending on the nature of the impingement, its relief might be accomplished by any of various methods of posturing, traction, or surgical decompression. A good treatment choice cannot be made until the exact location and cause of the impingement are identified.

In the meantime, a neutral position of the vertebral column is the position most likely to relieve pressure. For this purpose and to facilitate emergency therapeutic measures such as airway suction, cardiopulmonary resuscitation or tracheostomy, the patient should be placed on his back as soon as possible.[1] If pain, paralysis, or sensory loss indicate that the injury is cervical, light isotonic traction will facilitate stabilization. However, isotonic traction is possible only after the patient has been placed on a hospital stretcher. Unfortunately, if traction appliances are used on the patient while he is in a moving ambulance, force levels on the cervical spine are likely to vary widely. Manual stabilization of the patient's head by an alert attendant, without any attempt at traction, is probably the safest possible immobilization technique during transportation.

After arrival at a hospital and until definitive care is rendered, special systems to maintain immobilization of the neck are possible and are justified. Repeated transfer of a patient from one surface to another is hazardous and entirely unnecessary if proper equipment is available and forethought is used. A portable lightweight X-ray penetrable lifter to which a traction system can be attached should be used (Fig. 2).[2] When an accident victim arrives in a hospital, he should be moved directly from the ambulance stretcher onto such a lifter, and traction should be applied immediately. The lifter can be shifted from one stretcher to another or to an X-ray

or operating table without disturbing either the patient or his traction. With a lifter, the patient can easily be placed on a turning frame such as the Stryker. After the anterior portion of the Stryker frame has been fastened down, the frame, with the patient clamped inside against the lifter, can be rotated to the prone position. The posterior portion of the Stryker frame is then unfastened and the lifter is removed. With this technique the patient can be positioned face down for myelography or laminectomy with minimum risk of altering spine posture or traction force. If surgery is necessary, a comfortable operating height can be obtained by lifting all four wheels of the frame onto footstools. With this technique either an anterior or posterior surgical approach to the cervical spine can be made with much less risk of irritating the spinal cord than if the patient is transferred to an operating table.

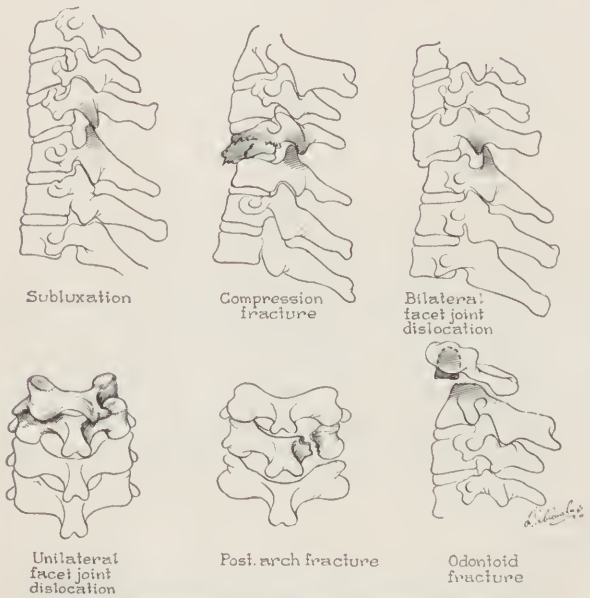


Fig. 1: Disruptions of the vertebral column.



Fig. 2: Cervical traction system can be attached directly to a portable X-ray penetrable lifter. Movements of the patient for X-rays or surgery are minimized.

Decompression

The patient's neurological status and the cause of the cord compression, as revealed by conventional and special X-ray studies such as myelography and laminography, determine which of several methods of decompression and stabilization will be most effective and least hazardous. The age of the patient, his normal activities and other aspects of his general health also influence the choice of treatment. The following possibilities exist:

1. Impingement no longer exists, therefore decompression is not indicated.
2. Impingement no longer exists but the spinal cord will swell until impingement recurs; therefore, prophylactic surgical decompression is indicated.
3. Impingement exists which can be relieved by adjustment of traction.
4. Impingement exists anteriorly which can be relieved by vertebral corpectomy (Fig. 3).
5. Impingement exists anteriorly which can be relieved by vertebral laminectomy. (Although this practice is widespread, the author believes that regardless of denticulatotomy, the restraining effect of the nerve roots and delicacy of the spinal cord prevent adequate mobilization of the cord for this method to be effective.)
6. Impingement exists posteriorly which can be relieved by vertebral laminectomy (Fig. 4 A & B).
7. Impingement exists both anteriorly and posteriorly which can be relieved by combined corpectomy and laminectomy (Fig. 4 C).

Stabilization

Definitive stabilization is accomplished by intrinsic, external, and operative methods. Immediately following vertebral or cord injury, some degree of temporary intrinsic stability is provided by spasm of adjacent para-vertebral muscles. Tightening of the trapezii draws up both shoulders. This protective reflex splints the injured neck. It may also complicate X-ray visualization of C7 and T1 . In view of a high frequency of injury in this area, adequate visualization is essential. Caudal traction on both upper limbs, or caudal traction on one limb and cephalic positioning of the other, "Swimmer's Position", may be necessary to obtain satisfactory lateral views.

External Techniques

Either temporary or definitive stabilization can be achieved by a wide variety of external techniques. Immobilization with head halter traction is a reasonable temporary precaution for any patient with a neck injury, but as soon as the diagnosis of either a spinal cord injury or an unstable vertebral column is established, skeletal traction with skull tongs should usually

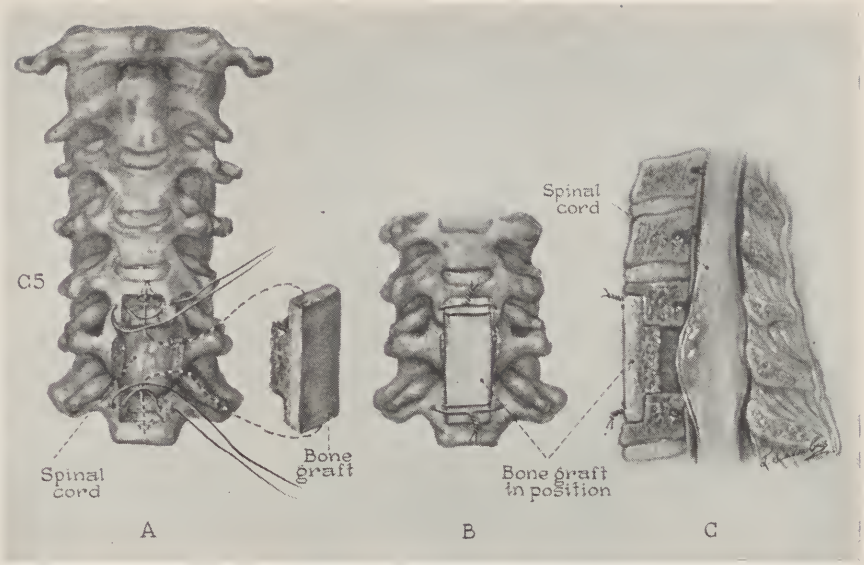


Fig. 3: Vertebral corpectomy and interbody strut fusion.

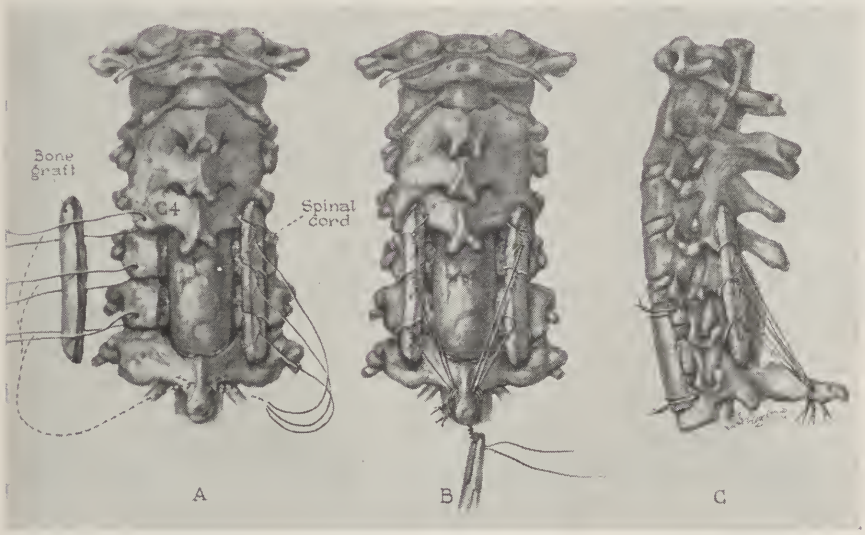


Fig. 4: Vertebral laminectomy and bilateral strut fusion with check reins. Lateral view, C, shows corpectomy and interbody fusion in association with the laminectomy and posterior fusion.

be applied.[3] A disadvantage of sustained head halter traction is that the skin over the mandible cannot indefinitely tolerate a constant compression force exceeding five pounds. Skeletal traction permits application of substantially higher forces. Forces high enough to reduce some fractures and dislocations can be used. However, the patient's neurological status should be monitored very carefully during such attempts. Traction loads in excess of 35 lbs are especially likely to increase neurological deficit.

A lateral turning device such as the Stryker Wedge Frame is always indicated for any patient in skeletal traction. The cephalic end of the frame should be elevated in proportion to the magnitude of the traction force. Although skeletal traction on a turning frame is easily adjusted and provides unobstructed access to the patient for surgery and nursing care, prolonged recumbency handicaps rehabilitation efforts and is demoralizing for the patient. Furthermore, skull tongs usually penetrate the inner table of the skull or disengage within several weeks. If more prolonged immobilization is required, the Rancho Los Amigos Halo apparatus is an alternative which has the advantage of permitting the patient to sit up and move about (Fig. 5).[4] The skull is held by four pins passing through a steel ring which is fastened by steel rods to a snug body jacket. The body jacket is carefully molded to grip the pelvis. A Minerva plaster cast, which encases the head and trunk, is another alternative, but it is less comfortable and does not stabilize the spine as securely as the Halo. Due to shoulder mobility, shoulder-based braces and cervical collars provide only slight immobilization. They shift about when the patient lies down and usually impinge on the throat when the patient is in a prone position. They are useful primarily when patients are sitting or walking and only if minimum support is needed.

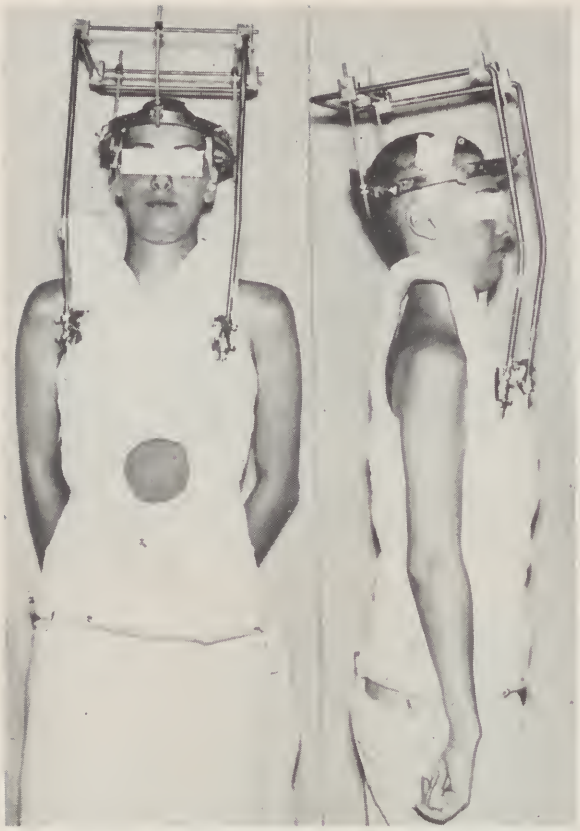


Fig. 5: The Rancho Los Amigos Halo apparatus provides secure immobilization of the cervical spine but permits sitting and ambulation.

Internal Techniques

Surgical methods of stabilization include many types of spine fusions. These may be classified into anterior and posterior types. If a fusion is justified, the type performed may be determined by the procedure selected to decompress the cord and realign the vertebral column. If anterior decompression by anterior discectomy or corpectomy is performed, a bone plug is placed between the portions of the vertebral bodies remaining above and below the surgical defect (Fig. 3). If fusion is performed posteriorly and the spinous processes and laminae were not fractured or surgically removed, the spinous processes can be fastened together with wire and bone grafts. On the other hand, if a cervical laminectomy has been performed, fusion must be performed between remaining portions of the articular processes of the facet joints. A satisfactory method is to wire each of these processes to longitudinally placed bone struts (Fig. 4).[5]

Selection of the best combination of methods of stabilization for a specific case can be as difficult and arbitrary as selection of the best method of decompression. The ideal combination is one which permits the patient to move or be positioned for maximum use of his residual neuromusculoskeletal functional capabilities in the shortest time, with least encumbrance by immobilizing apparatus and without suffering additional loss of neurological function secondary to increased impingement or re-impingement of vertebral elements on the spinal cord or nerve roots. Any known method or combination of methods of stabilization can fail. In selecting methods, both the probabilities for a successful outcome and the magnitude of potential losses from an unsuccessful outcome must be considered. The magnitude of existing neurological loss should not be allowed to influence the duration of prescribed immobilization. A patient with a minor deficit has everything to lose if displacement occurs. A patient with a major deficit must place great reliance on his few remaining capabilities. Therefore, in the latter patient, an apparently trivial additional loss is disastrous.

Stress Ulcers

In the author's experience, the most common cause of death during the early phase of the care of patients with spinal cord injuries is not decubitus ulcers or respiratory or urinary tract infection, but peptic ulcer perforation. Since these patients may lack abdominal pain perception, the first clues to this complication are high fever, abdominal swelling, shock, and hematemesis. If these symptoms develop, immediate laparotomy and repair of the ulcer are necessary. For these reasons, all spinal cord injury patients should be initially placed on a prophylactic ulcer regimen.

Mobilization

After stabilization has been obtained, the patient can be mobilized. Mobilization is necessary to prevent pressure sores and permit development of the patient's potential abilities for self-care. This entails turning, sitting, transfer, wheelchair management, activities of daily living, etc. As a prelude to these activities, the legs must be wrapped to minimize swelling. All limb joints must be ranged daily. When not being ranged, paralyzed hands must be splinted in a functional position with the thumb-web stretched and the thumb held opposite the first two fingers. When at rest, the shoulder should be placed in abduction and moderate external rotation. These measures must be started within several days after the initial injury. Neglect of these measures inevitably permits rapid development of disabling contractures.

Pressure sores are more likely to develop some three weeks following the injury rather than before. No method for their prevention is known which is as effective as turning the patient faithfully at least every few hours. Special pads, mattresses, circle beds, and flotation devices are merely helpful aids in preventing pressure sores. They are not satisfactory substitutes for frequent turning.

Although some useful upper limb activities can be pursued with the patient recumbent, these activities become rewarding only when the patient can be placed in a sitting position. Every effort should be made to sit the patient up as soon as possible. In order to minimize dizziness, exhaustion, and lower limb edema, these initial periods of sitting should be short and frequent. As the patient adapts to the sitting position, these periods should be lengthened. However, especially when the patient is sitting up, special attention must be given to positioning and relief of pressure on the feet. Patients who have an ambulatory potential due to minor cord involvement must be allowed to stand and walk as soon as possible with whatever ambulatory aids are necessary. Patients without ambulatory potential should be adapted to properly sized wheelchairs with whatever accessories such as removable arm rests, head rests, trunk stabilizers, ball bearing feeders, and power systems are indicated. These devices must be carefully prescribed with full knowledge of the limitations of this equipment and the specific needs of the patient. If properly used, electric circle beds with their special turning, tilting, positioning, and transfer features are valuable labor-saving aids in handling and verticalizing either ambulatory or nonambulatory patients.

Functional Splinting

Upper limb functional splints or surgical procedures can substantially enhance the functional abilities of patients with spinal cord injury. As the specific level and extent of permanent neurological deficit become evident, a correct choice of appliances or operations can be made. Due to emergence of each cervical nerve root from the spinal cord at a level higher than the intervertebral level through which it emerges from the spinal canal, total cord injury at any specific intervertebral joint level will usually be associated with sparing of the nerve root emerging from the spinal canal at that level. For example, in a C4-5 vertebral injury, C5 root may escape permanent injury. In this situation, the deltoid and biceps muscles will be functional but not the wrist, hand, or finger muscles. In these cases upper limb function is greatly improved with mobile arm supports and externally powered flexor hinge hand splints. In a C5-6 injury, C6 root may escape injury. In this case, pectoralis major, deltoid, biceps, brachial radialis, supinator, extensor carpi radialis longus, extensor carpi radialis brevis, pronator teres, and flexor carpi radialis muscles, but none of the finger extensors or flexors, will be functional. These patients can benefit from wrist driven hinge splints. In C7-T1 vertebral injuries, C8 root may recover. In addition to function of the above muscles, there will be varying degrees of function of extrinsic finger flexors and extensors. Usually the intrinsics do not recover. A short opponens hand splint with a metacarpo-phalangeal flexion bar is helpful.

Reconstructive Surgery

In a C5-6 injury with good wrist extensors, interphalangeal joint fusion with flexor tendon tenodesis can be substituted for a flexor hinge hand splint. Although an intermetacarpal bone block can be used to maintain thenar web space, an opponens splint is preferable, since the patient can remove it and flatten his hand in order to transfer himself from one surface to another. In C6-7 injuries, the following transfers for improved hand function have been suggested: extensor carpi radialis longus into finger and thumb extensors, brachio-radialis into long thumb flexors, pronator teres into flexor digitorum profundus, and flexor carpi radialis with tendon graft for opposition.

Selection of any of these procedures should be made only after careful observation of how the patient uses his disabled hands during all of his activities. Due to the narrow functional reserve of most of these hands, a procedure which improves one function may prevent another more important function.

Summary

Neurological deficit from transection of the spinal cord is permanent. Salvage of neurological function equivalent to a single nerve root justifies reduction or decompression and stabilization by specific techniques appropriate to the specific nature of the lesion. Successful rehabilitation requires early mobilization and knowledgeable use of assistive equipment and reconstructive procedures. Although care of the patient with spinal cord injury requires the knowledge and skills of many different types of personnel, optimal end results cannot be achieved unless the responsible physician or surgeon has a thorough knowledge of resources available, a consummate skill in their use, intimate familiarity with every detail of the individual case, and most of all, a personal interest in the management of these patients. Five thousand years after the first recorded comments on this condition, the care of the patient with a spinal cord injury remains one of the medical profession's most challenging problems.

REFERENCES

1. Schmeisser, G.: The Initial Management of Fractures, *The Management of Trauma,* W. F. Ballinger II, R. B. Rutherford, and G. D. Zuidema (eds.), Philadelphia: Saunders, 1968.
2. Schmeisser, G.: The Acutely Injured Patient, *Physical Diagnosis: A Physiologic Approach to the Clinical Examination,* 2nd Edition, R. D. Judge and G. D. Zuidema (eds.), Boston: Little, Brown, 1968.
3. Schmeisser, G.: *A Clinical Manual of Orthopedic Traction Techniques,* Philadelphia: Saunders, 1963, p. 53.
4. Nickel, V. L., et al: The Halo: A Spinal Skeletal Traction Fixation Device, *Jour Bone & Joint Surg* **50-A:**1400, 1968.
5. Robinson, R. A., and Southwick, W. O.: Indications and Techniques for Early Stabilization of the Neck in Some Fracture Dislocations of the Cervical Spine, *Southern Med Jour* **53:**565, 1960.

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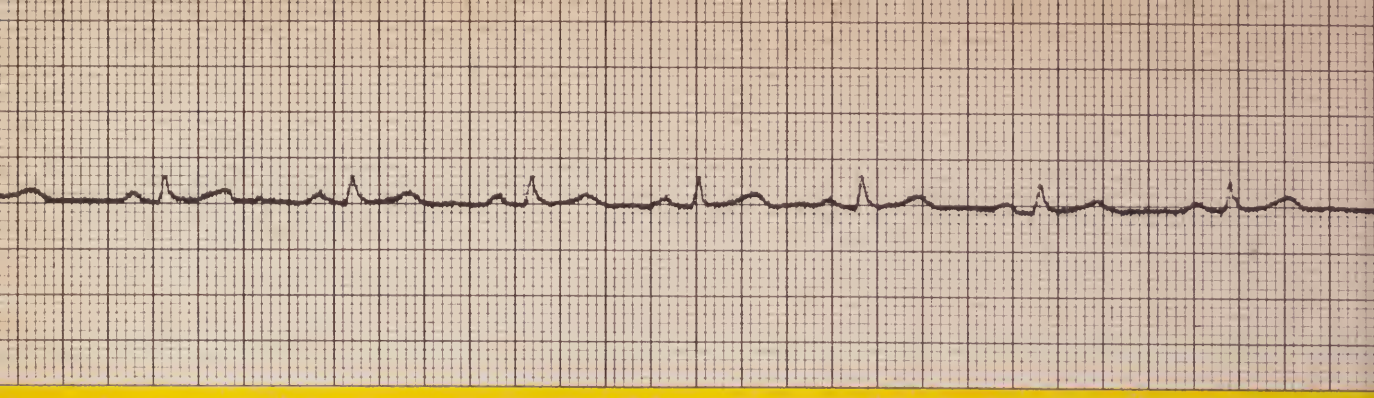
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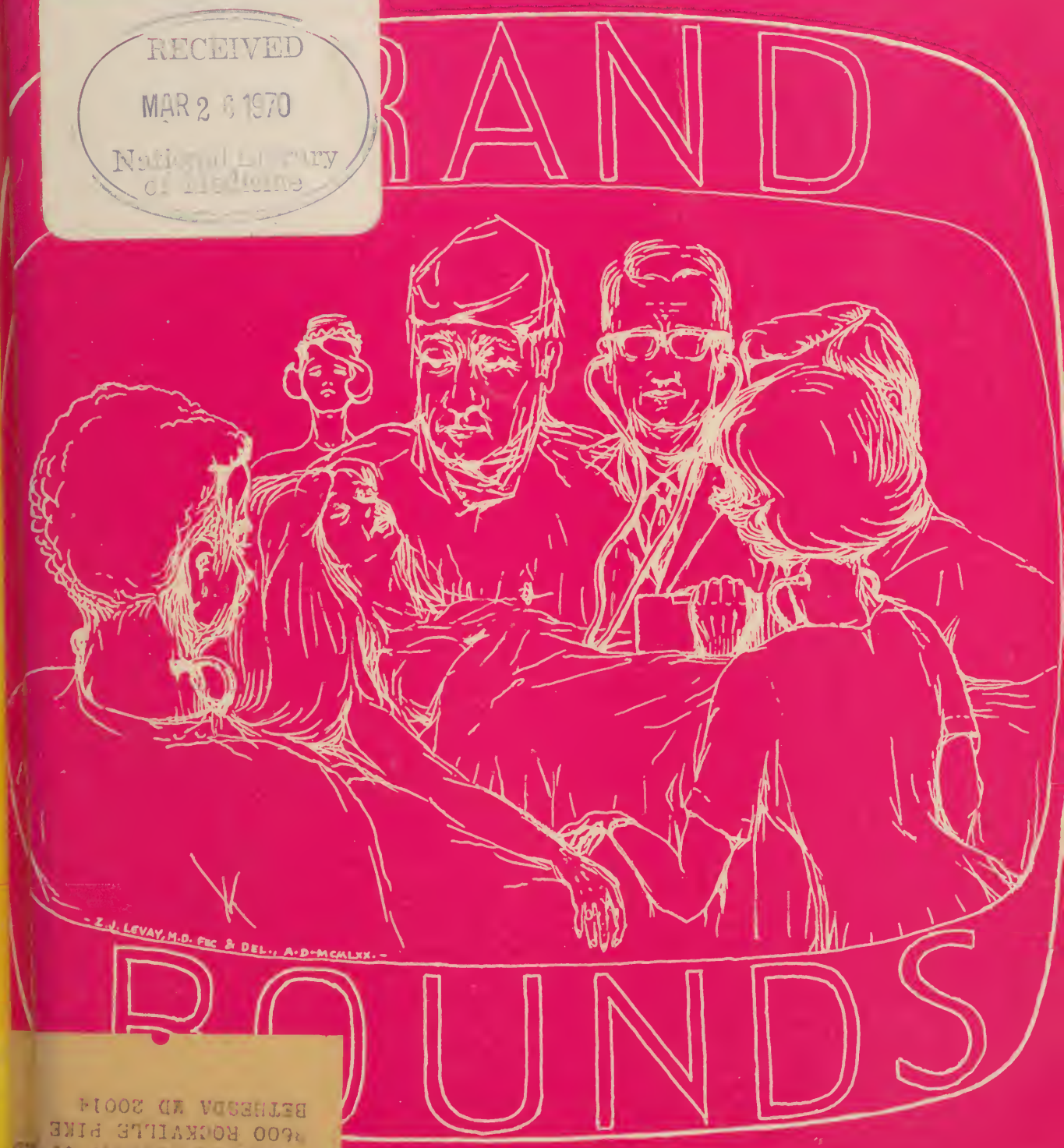
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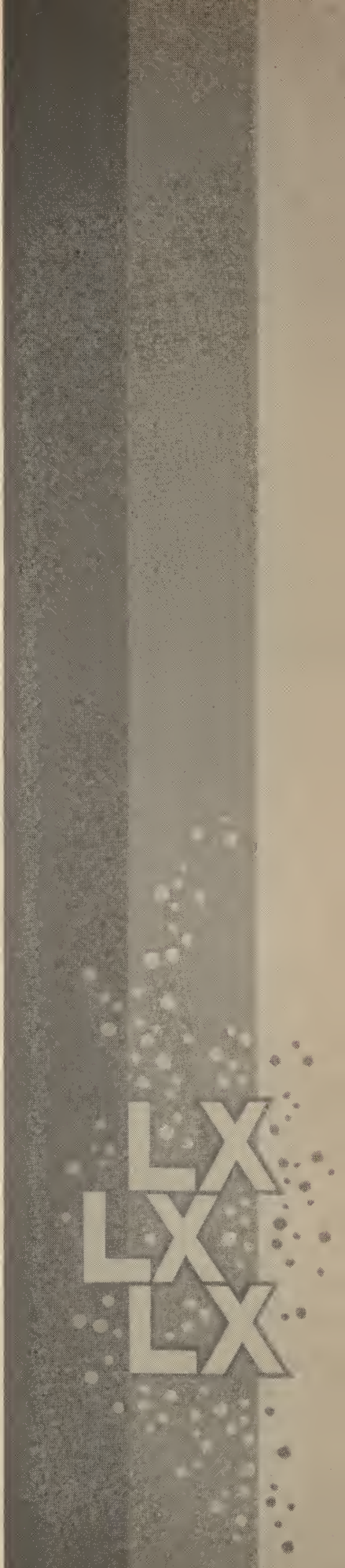
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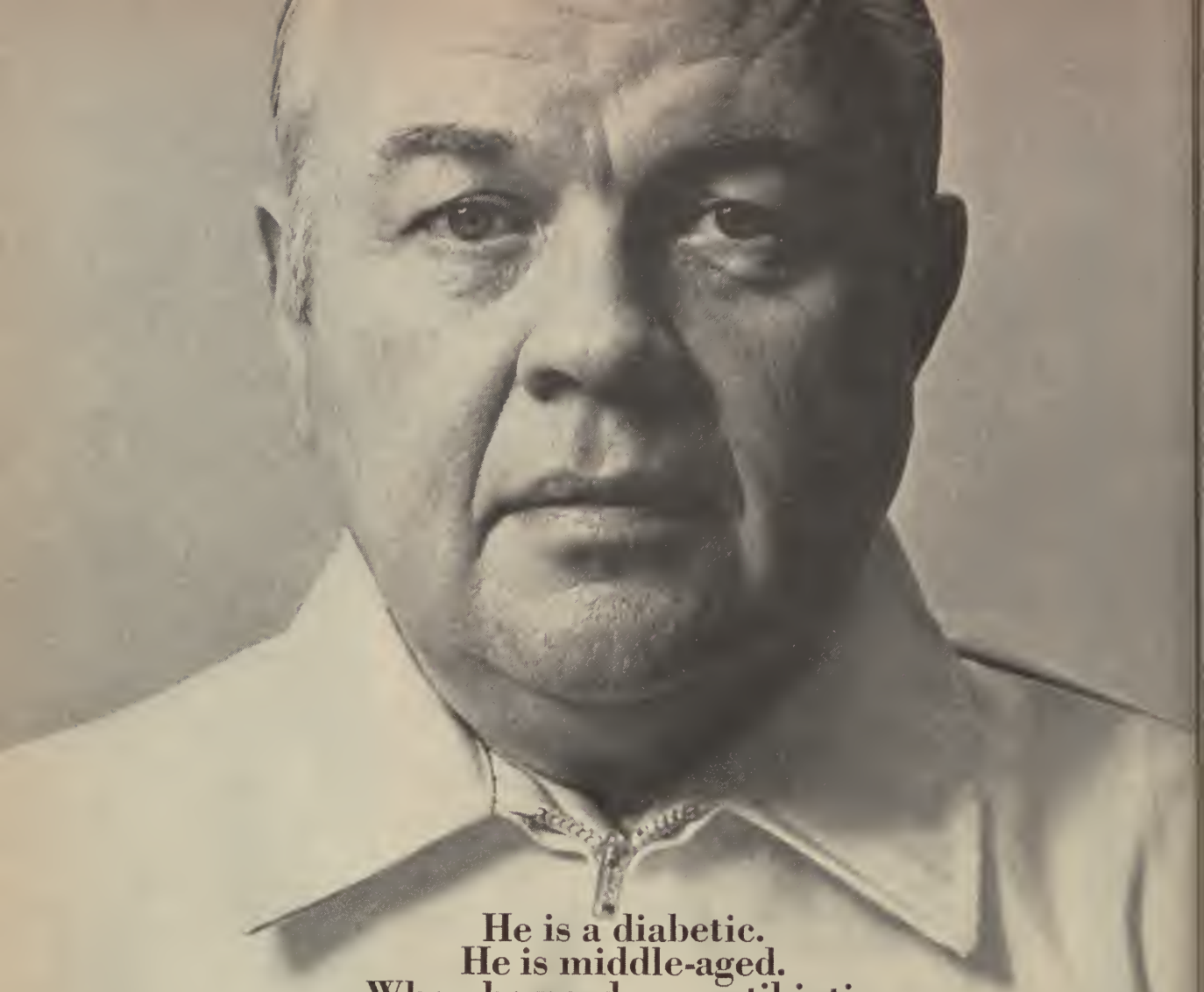
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D.J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.



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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. stant observation is essential. If new infections appear, appro measures should be taken. In infants, increased intracranial pre with bulging fontanels has been observed. All signs and symptoms disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—macul ular and erythematous rashes; a rare case of exfoliative dermatiti been reported. Photosensitivity; onycholysis and discoloration o nails (rare). Kidney—rise in BUN, apparently dose related. Tran increase in urinary output, sometimes accompanied by thirst (i Hypersensitivity reactions—urticaria, angioneurotic edema, anaphyl Teeth—dental staining (yellow-brown) in children of mothers given drug during the latter half of pregnancy, and in children given the during the neonatal period, infancy and early childhood. Enamel h plasia has been seen in a few children. If adverse reaction or idi crasy occurs, discontinue medication and institute appropriate the Demethylchlortetracycline may form a stable calcium complex in bone-forming tissue with no serious harmful effects reported thu in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shoul given 1 hour before or 2 hours after meals, since absorption is impa by the concomitant administration of high calcium content drugs, f and some dairy products. Treatment of streptococcal infections sh continue for 10 days, even though symptoms have subsided.

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VOLUME 19 MARCH 1970 NUMBER 3

CONTENTS:

Editorial—Organ and Tissue Donation Made Easier, John Sargeant .. 44

Jejunocolostomy For Obesity, Charles E. Wills, Jr., MD 45

"Three cases are presented which show that jejunocolostomies resulted in marked weight losses. Detailed accounts of these cases demonstrated the severe side effects and numerous postoperative complications. Because the purpose of the paper is to demonstrate the problem involved in the jejunocolostomy, the periods following the revisions are developed briefly."

Surgical Grand Rounds 51

The Surgical Grand Rounds were presented at the Med-Chi Annual Meeting in April 1969. George D. Zuidema, MD, Professor of Surgery and Chairman of the Department at The Johns Hopkins University School of Medicine, served as moderator.

Intrasynovial Corticosteroid Therapy in Arthritis, Joseph Lee Hollander, MD 62

"I am not a geriatrist, in that I do not limit my practice of medicine to those in their declining years. Actually, however, as a rheumatologist or 'arthritis specialist', I have found myself intimately concerned with many painful afflictions that seem to be an inescapable part of what can euphemistically be called our 'period of receding youth'.

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 68

Maryland State Department of Health—Laboratory Tests for Rubella and Their Interpretation, J. Mehsen Joseph, PhD 71

Tuberculosis—Significance of Intermediate Levels of Antitrypsin Deficiency in Pulmonary Disease 89

Heart Page—The Master's Two-Step Exercise Tolerance Electrocardiograph Test: Part 2, Luis F. Gonzalez, MD 93

Alcoholism—Admissions to the Alcoholic Rehabilitation Unit of Crownsville State Hospital, Gregory S. Mestanas 101

Maryland State Department of Mental Hygiene—Is There A Revolving Door? 105

Rehabilitation Notes—Cervical Spine Injuries, J. Donald McQueen, MD 109

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The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

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ON THE COVER: This month's rendition of Grand Rounds is another original contribution by **Z. John Levay, MD.** The Journal staff is indeed indebted to Dr. Levay for his creative efforts.

Doctors Take Note **5**

Executive Secretary's Newsletter **9**

Annual Meeting Program **20**

Annual Meeting Speakers **23**

Annual Meeting Exhibitors **24**

Book Reviews **27**

MEDIC **29**

Arts and Hobby Exhibit **31**

Hotel Reservation Form **32**

Orient Tour **33**

Medical News **34**

Doctors' Day **67**

Component Society News **79, 85, 91**

AMA Priority Objectives **81**

Baltimore Association of Medical Assistants **83**

Woman's Auxiliary **95**

Information For Authors **108**

Advertising Index **115**

Classified Advertising **116**


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Doctors take note...

MARCH 14, 1970
HEART ASSOCIATION OF MARYLAND/MARYLAND ACADEMY OF GENERAL PRACTICE

Symposium—Myocardial Infarction, Before and During Hospitalization: 10 AM to 4 PM, South Baltimore General Hospital, Baltimore, Md. Contact: Mrs. Tyson (301) 685-7074, or Mrs. Holman (301) 661-1925.

MARCH 18, 1970
AMERICAN FERTILITY SOCIETY

Postgraduate Courses—Infertility, Family Planning, Genetic Counseling: Washington, D.C. Contact: Alvin F. Goldfarb, MD, Department of Ob-Gyn, Jefferson Medical College of Philadelphia, 1025 Walnut St., Philadelphia, Pa. 19107.

MARCH 18-21, 1970
AMERICAN FERTILITY SOCIETY

Annual Meeting: Washington, D.C. Contact: Herbert H. Thomas, MD, 944 South 18th St., Birmingham, Ala. 35205.

MARCH 23-26, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Neurology and the Internists: Mann Hall, Medical Sciences Building, 321-3rd Avenue, SW, Rochester, Minn. Director: Clark H. Millikan, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 30-APRIL 3, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Rheumatic Diseases: Pathogenesis, Diagnosis and Treatment: University of Michigan Medical Center, Ann Arbor, Mich. Director: William D. Robinson, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 30-APRIL 4, 1970
UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE

Course—Maxillofacial Anatomy and Surgery: Anatomy Laboratories of the School of Medicine, and the Graduate Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania. Fee: $100 (surgery only); $100 (anatomy only); both sessions $175. Contact: Office of Graduate Medical Education, 288 Medical Laboratories Building, University of Pennsylvania, Philadelphia, Pa. 19104.

MARCH 31, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—The Renin-Angiotensin System: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Speaker: Glenn D. Lubash, MD.

APRIL 1-5, 1970
HUTZEL HOSPITAL

Course—Mammography: Detroit, Michigan. Contact: Hutzel Hospital, 432 East Hancock, Detroit, Mich. 48201.

APRIL 4, 1970
AMERICAN ASSOCIATION OF MEDICAL CLINICS

Southeastern Regional Meeting: Lloyd Noland Hospital and Clinic, Fairfield, Alabama. Contact: Leon C. Hamrick, MD, Lloyd Noland Hospital, Fairfield, Ala. 35064.

APRIL 6-8, 1970
EUROPEAN ASSOCIATION OF PERINATAL MEDICINE

European Congress of Perinatal Medicine: London, England. Contact: Prof. P. J. Huntington, European Association of Perinatal Medicine, 11 Whitehall Court, London SW 1, United Kingdom.

APRIL 6-9, 1970
UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

Postgraduate Session—Obstetrics-Gynecology: Colorado Springs, Colorado. Contact: University of Colorado School of Medicine, Office of Postgraduate Education, 4200 East 9th Ave., Denver, Colo. 80220.

APRIL 6-17, 1970
DEPARTMENT OF OTOLARYNGOLOGY, UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE

Postgraduate Course—Laryngology and Bronchoesophagology: Eye and Ear Infirmary, University of Illinois Hospital, 1855 West Taylor Street, Chicago, Ill. The course is limited to 15 physicians. Contact: Department of Otolaryngology, College of Medicine, University of Illinois at the Medical Center, P.O. Box 6988, Chicago, Ill. 60680.

APRIL 8, 1970
WASHINGTON HEART ASSOCIATION/HEART ASSOCIATION OF NORTHERN VIRGINIA, INC.

13th Annual Joint Cardiac Symposium: Persian Room, The Marriott Twin Bridges Motor Hotel, Washington, D.C. For additional information, write: Mrs. Anna C. Van Sickler, Executive Director, 609 N. Edgewood St., Arlington, Va. 22201.

APRIL 8-10, 1970
UNITED STATES PHARMACOPEIA

Decennial Meeting: Shoreham Hotel, Washington, D.C. Those bodies that are entitled to representation at the meeting are requested to appoint a delegate and an alternate delegate in compliance with the Constitution and Bylaws of the United States Pharmacopeial Convention. Contact: Secretary of the U.S. Pharmacopeia, 4630 Montgomery Ave., Bethesda, Md. 20014.

APRIL 9-10, 1970
COUNCIL ON RURAL HEALTH, AMERICAN MEDICAL ASSOCIATION

23rd National Conference on Rural Health: Pfister Hotel and Tower, Milwaukee, Wisconsin. The conference will include a panel discussion and a symposium. There is no registration fee. Contact: Bond L. Bible, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

APRIL 9-10, 1970
AMERICAN ASSOCIATION OF PLANNED PARENTHOOD

Eighth Annual Meeting: Boston, Massachusetts. Contact: George J. Langmyhr, MD, Planned Parenthood Federation, 515 Madison Ave., New York, N.Y. 10022.

APRIL 9-11, 1970
AMERICAN COLLEGE OF PHYSICIANS/AMERICAN PHYSIOLOGICAL SOCIETY

Postgraduate Course—Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems: The Holiday Inn, Philadelphia, Pennsylvania. Director: Daniel H. Simmons, MD, FACP. Write: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

(Continued on page 86)

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executive secretary's newsletter

March, 1970

In a comparative analysis of increases in costs of living, U.S. News & World Report (January 19, 1970) indicates the following percentage changes occurred within the last five years:

physicians' fees up	37.8%
auto insurance up	38.1%
mortgage insurance up	39.2%
household workers up	44.7%
hospital operating room up	67.4%
semiprivate hospital room up	86%
dentists' fees up	30.4%
haircut up	32.9%

NEW AMA APPOINTMENT

Theodore R. Chilcoat, Jr., formerly a Faculty employee, who left to join the AMA Field Service Division in 1965, has been named Director of the Specialty Society Services Department.

1970 PRESIDENTIAL DINNER

The 1970 Presidential Dinner will be held at Blue Crest North on Thursday, April 2, 1970. Tickets, $14 a person, include cocktails before and after dinner; hors d'oeuvres, dinner, dancing, and all gratuities.

Look for reservation envelopes in the mail shortly.

FACULTY QUESTIONNAIRE

A questionnaire soliciting members' advice on the use of various Faculty services or lack of services will be enclosed with the next issue of THE ASSEMBLYMAN.

Members are urged to complete the questionnaire and return it in the special, self-addressed envelope. It is only through each member's response that the Faculty can assess the value of and improve its services.

APPRECIATION TO MEMBERS

Faculty thanks go to those members who have been of inestimable help in contacting legislators during the current session of the General Assembly. Personal contacts by constituents do much to convey the profession's interest in health care and related matters.

If your Component Society has not met with its General Assembly delegation, you are urged to make arrangements for such a meeting. Faculty staff and officers are available to assist you in this regard.

1970/71 COMMITTEE APPOINTMENTS

The President-elect is currently making Committee appointments for the 1970/71 Faculty year. Selections will be made, primarily, from the return card sent all members several months ago.

For those who did not respond, it is not too late to make your wishes known.

ORIENT TRIP

There are still a few places left on the Orient trip leaving from Friendship Airport on May 1. Interested persons should contact Mrs. Beverly Wolins, at Travel Guide Agency, SA-7-1696.

No definitive plans have been completed for scientific meetings in Tokyo and Hong Kong, although it is anticipated that details will be available shortly.

TRIP TO ENGLAND

A possibility exists that the Faculty will have a Charter trip to England for a 7-day period, leaving Baltimore on June 9, 1970 aboard an Air India jet. If interested, contact the Faculty office for more details.

The more interest shown for such a trip, the more likely its availability will be assured.

HEALTH INFORMATION SURVEY

A six-week U.S.P.H.S. Health Examination Survey is being conducted in the Georgetown, Delaware, area. The survey, begun February 9, and scheduled to continue through March 31, 1970, is to determine the fitness of youths age 12 through 17.

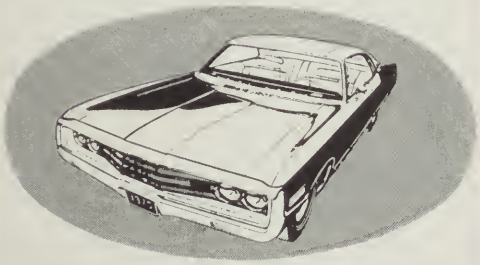
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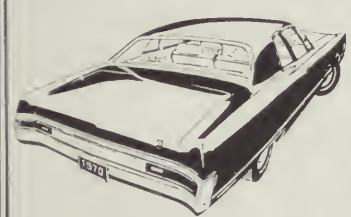
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General Adverse Effects: Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg/day, without corresponding clinical benefits; and 2) careful instructions to, and observations of, the individual patients are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Indications: Symptomatic relief of adult rheumatoid and degenerative joint disease unresponsive to adequate trial of salicylates and other measures of established value, such as appropriate rest. Has been found effective in active stages of: 1) moderate to severe rheumatoid arthritis including acute flares of chronic disease, 2) moderate to severe rheumatoid (ankylosing) spondylitis, and 3) moderate to severe degenerative joint disease of the hip (osteoarthritis of the hip). Has been found effective in relieving pain and reducing fever, swelling, and tenderness in acute gouty arthritis in selected patients. May enable reduction of steroid dosage in patients receiving steroids for the more severe forms of rheumatoid arthritis; in such instances the steroid dosage should be reduced slowly and the patients followed very closely for any possible adverse effects.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
Central Nervous System Effects: INDOCIN (Indomethacin, MSD) may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; gastrointestinal bleeding without obvious ulcer formation; perforation o preexisting sigmoid lesions (diverticulum, carc noma, etc.); rarely, increased abdominal pain i ulcerative colitis patients or development of u cerative colitis and regional ileitis; gastriti which may persist after the cessation of th drug; nausea, vomiting, anorexia, epigastric di tress, abdominal pain, and diarrhea.
Eye Reactions: Corneal deposits and retinal di turbances, including those of the macula, hav been observed on prolonged therapy; blurring o vision.
Hepatic Reactions: Rarely, toxic hepatitis an jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemo lytic anemia, bone marrow depression, agranulo cytosis, leukopenia, and thrombocytopenic pur pura. Since some patients manifest anemia sec ondary to obvious or occult gastrointestina bleeding, appropriate blood determinations ar recommended.
Hypersensitivity Reactions: Acute respiratory di tress, including dyspnea and asthma; angiitis pruritus; urticaria; angioedema; skin rashes.
Ear Reactions: Hearing disturbances, deafness tinnitus.
Central Nervous System Reactions: Psychotic epi sodes, depersonalization, depression, coma, con vulsions, peripheral neuropathy, drowsiness mental confusion, lightheadedness, dizziness headache.
Cardiovascular-Renal Reactions: Edema, elevatio of blood pressure, hematuria.
Dermatologic Reactions: Loss of hair, erythema nodosum.
Miscellaneous: Rarely, vaginal bleeding, hyper glycemia, glycosuria, ulcerative stomatitis, and epistaxis.

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Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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SHENANDOAH, JULY 16. Roger Sherman of Waynesboro suffered head lacerations but escaped serious injury when the tractor-trailer he was driving skidded on Deep Run Bridge and jackknifed. It took rescue workers thirty minutes to remove him from the cab which was dangling over the edge of the bridge. Sherman is resting comfortably in University Hospital where his condition is listed as satisfactory.

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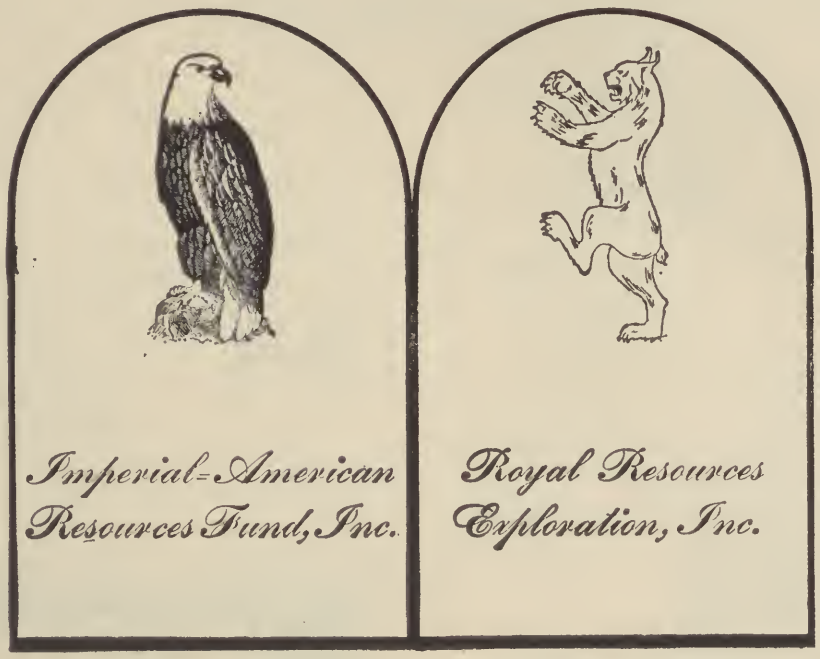
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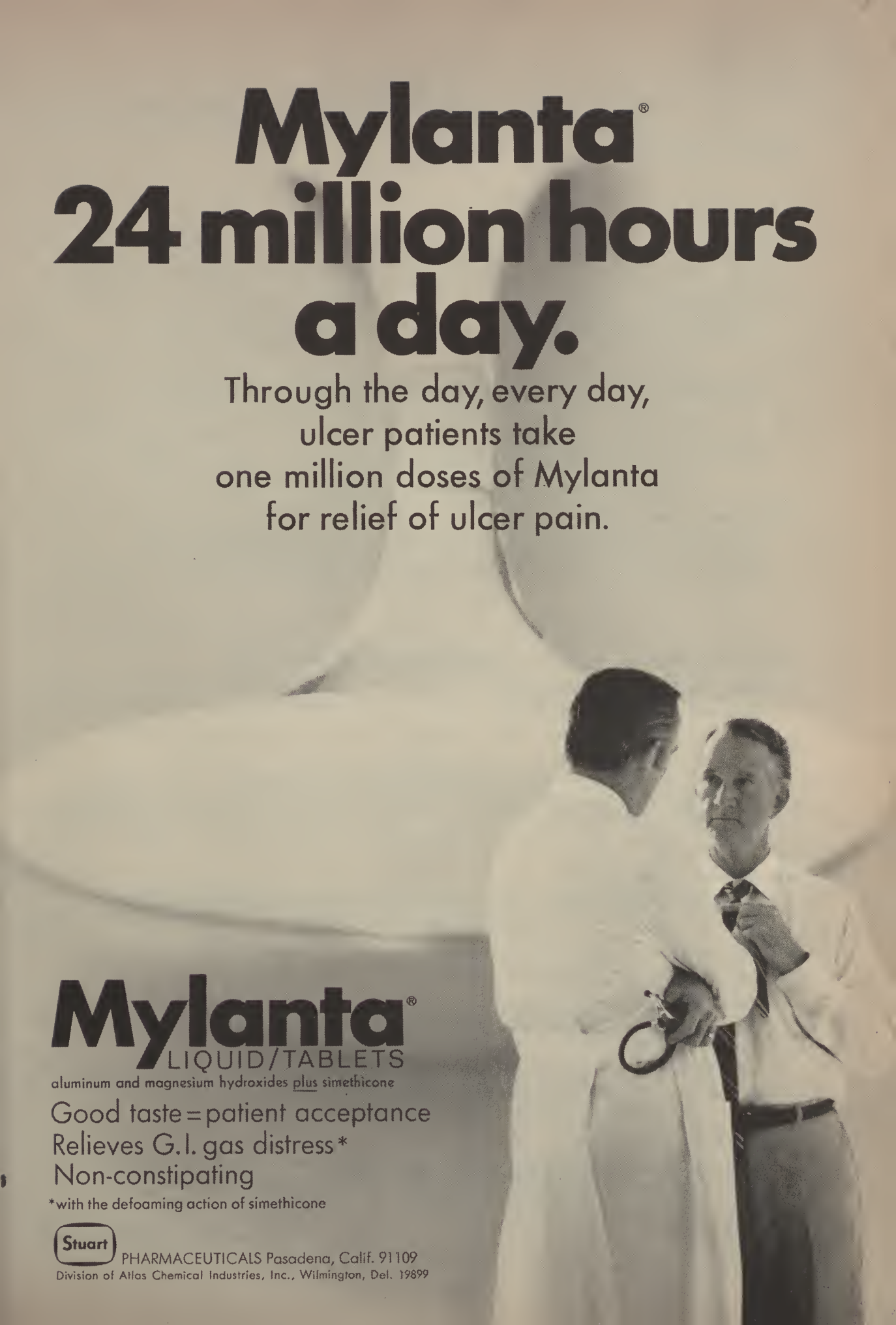
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ANNUAL MEETING PROGRAM

The Alcazar, Baltimore — *Wednesday, April 1, 1970*

9:30 AM—Meeting of the House of Delegates

2:00-4:30 PM—Scientific Session

2:00 PM—*Mental Health and the Physician: Who Worries About His?*
Roy W. Menninger, MD, President, The Menninger Foundation, Topeka, Kansas

3:00 PM—*The Future of Medical Education: Undergraduate and Postgraduate*
George James, MD, Dean, Mount Sinai School of Medicine, New York

3:45 PM—*The Emerging Physician's Assistant*
Hu C. Myers, MD, Medical Director, Chief of Surgery, Director of Career Clinic, Broaddus Hospital, Philippi, West Virginia

The Belvedere Hotel, Baltimore

5:30-7:00 PM—Hospitality Night for all members of the Faculty and their wives

6:30 PM—International Dinner and Entertainment sponsored by the Woman's Auxiliary

The Alcazar, Baltimore — *Thursday, April 2, 1970*

9:30 AM-Noon—Scientific Session

9:30 AM—*Medical Grand Rounds*
A. McGehee Harvey, MD, and Medical Staff of The Johns Hopkins University School of Medicine

11:15 AM—*Diagnostic Limitations of Body Fluid Enzyme Alterations: A Reappraisal*
Felix Wroblewski, MD, Associate Professor of Clinical Medicine, Cornell University Medical College, New York

Noon—Election of Board of Medical Examiners

The Belvedere Hotel, Baltimore

12:30 PM—**Annual Round Table Luncheon,** which will include meetings of the alumni associations of several medical schools, as well as the usual scientific subjects

The Alcazar, Baltimore

2:15-4:45 PM—Scientific Session

2:15 PM—*Surgical Grand Rounds*
Robert W. Buxton, MD, and Surgical Staff of the University of Maryland School of Medicine

4:00 PM—*Venous Bypass Grafting for Coronary Artery Disease*
Frank C. Spencer, MD, Professor and Chairman, Department of Surgery, New York University Medical Center

The Blue Crest North, Baltimore

6:15 PM—**Annual Presidential Reception and Banquet** in a delightful atmosphere with delectable cuisine, hors d'oeuvres, cocktails and dancing for all to the music of Rivers Chambers' Orchestra

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

The Alcazar, Baltimore *Friday, April 3, 1970*

9:15 AM-12:30 PM—Scientific Session

9:15 AM—*The Eye in Systemic Diseases*
Daniel M. Gordon, MD, Associate Professor of Ophthalmology, Cornell University Medical College, New York

10:00 AM—*The Harmful Use of Sex*
John Rock, MD, Clinical Professor Emeritus of Gynecology, Harvard Medical School

11:00 AM—*Pulmonary Embolism: Its Causes and Prevention*
William H. Moretz, MD, Chairman, Department of Surgery, Medical College of Georgia

11:45 AM—*Physical Examination of the Joints: A Challenge*
William P. Beetham, Jr., MD, Lahey Clinic Foundation, Boston

Osler Hall, Faculty Building, Baltimore

2:00 PM—Meeting of the House of Delegates

* * * * * * *

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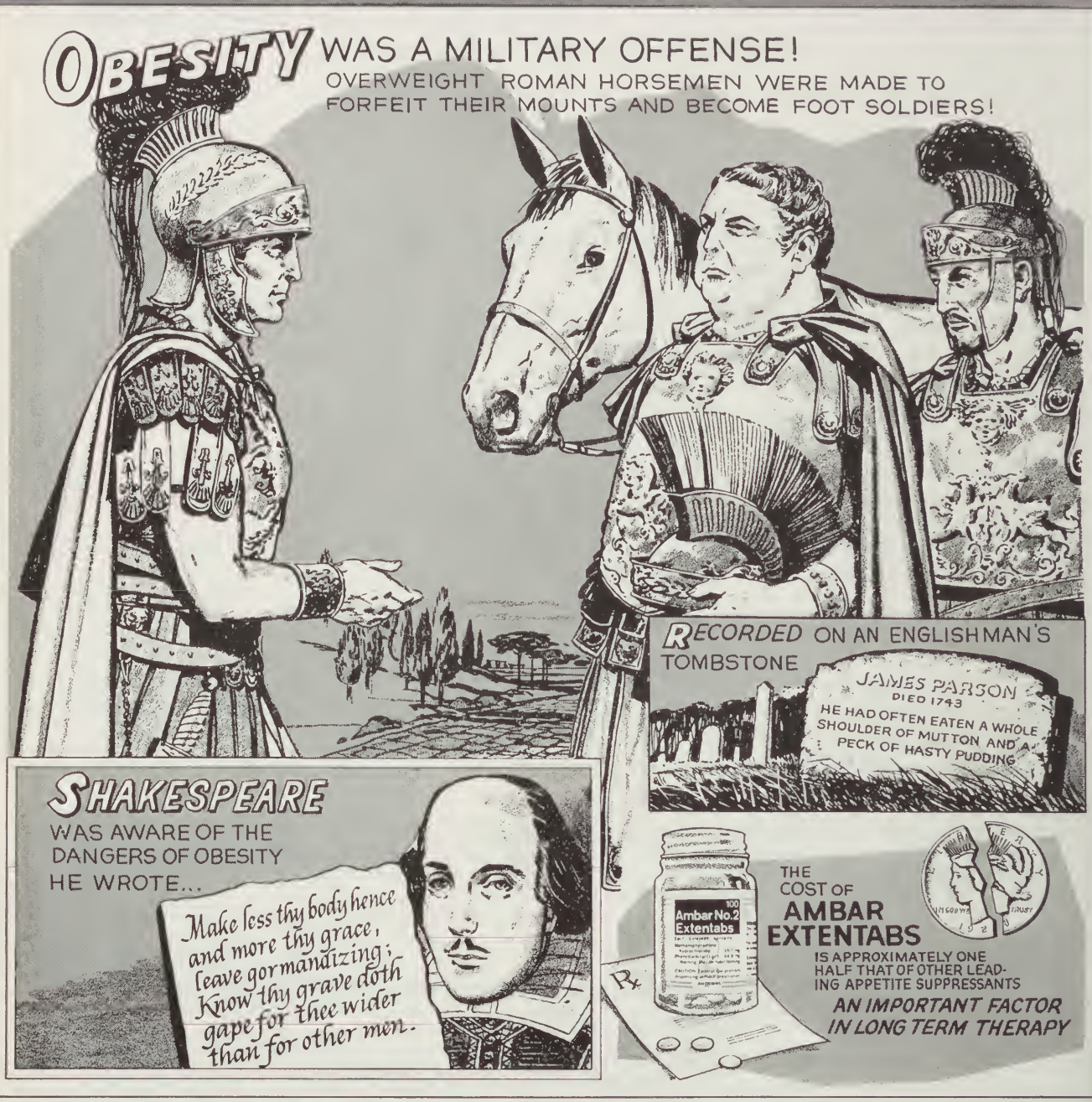
Wednesday, Thursday, and Friday
Intermissions will be provided to visit these exhibits which constitute a symposium on therapeutic progress.

(See page 24 for a list of Technical Exhibitors to date)

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APRIL 1, 2, 3, 1970

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172nd ANNUAL MEETING SPEAKERS
APRIL 1, 2, 3

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

Among the many prominent physicians who will speak at the Annual Meeting are **William P. Beetham, Jr., MD, and Felix Wroblewski, MD.***

William P. Beetham, Jr., MD, will deliver the George M. Boyer Lecture on "Physical Examination of the Joints—A Challenge," on Friday morning, April 3. His paper will present a method for conducting the physical examination of peripheral joints as a guide for the evaluation of joint involvement in the various rheumatic diseases. He will also serve as moderator at one of the round-table luncheons on Thursday, April 2, leading the discussion on "Collagen Disorders."



Dr. Beetham

Dr. Beetham was born in Boston and graduated from Ohio Wesleyan University. He received his MD degree from the University of Rochester Medical School in 1955 and interned at the Boston City Hospital. After two years in the Army Medical Corps, he became a Fellow in Medicine at the Mayo Clinic from 1958 to 1962. He was an Assistant Professor of Medicine at the University of Alabama Medical Center from 1962 to 1965. Dr. Beetham has been on the staff of the Lahey Clinic Foundation in Boston since 1965 as a rheumatologist in the Department of Internal Medicine. He is also a staff member of the New England Deaconess and New England Baptist hospitals.

He is a member of the American Board of Internal Medicine and is a Fellow of the American College of Physicians. Dr. Beetham is senior author of the book, *Physical Examination of the Joints* (W. B. Saunders), and has published 41 medical articles.

"Diagnostic Limitations of Body Fluid Enzyme Alterations: A Reappraisal" is the title of the Jesse C. Coggins Fund Lecture to be delivered by **Felix Wroblewski, MD,** Thursday morning, April 2. He will also moderate the round-table luncheon discussion of "What's the Matter with Doctors?" A native of New York city, Dr. Wroblewski received his BA degree from New York University in 1942 and his MD degree from the Medical College of that university in 1945. He served an internship at Bellevue Hospital in New York from 1945 to 1946 and was appointed to fellowships in clinical medicine, medicine, and biochemistry at the Sloan-Kettering Institute. He is board certified in internal medicine. He served in the Army Medical Corps from 1946 to 1948, and taught at Cornell University Medical College from 1952 to 1968. He also served as Visiting Professor at the University of Venezuela College of Medicine in 1961.



Dr. Wroblewski

Dr. Wroblewski has been appointed to several research positions, and served as consultant to the Diagnostic Research Branch of the National Institutes of Health in Bethesda in 1961. He has received numerous awards for research and service, including the Hekoen Bronze Medal from the AMA in 1955.

He is a member of such organizations as the American Federation for Clinical Research, the American Association for the Advancement of Science, and the American Medical Association. He was Director of the American Cancer Society, and is a Fellow of the American College of Physicians.

* See the January and February Journals for capsule biographies of **Roy W. Menninger, MD, George James, MD, Daniel M. Gordon, MD, William H. Moretz, MD, John Rock, MD, Hu C. Myers, MD, and Frank C. Spencer, MD.**

THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM of the MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING at the Alcazar APRIL 1, 2, 3, 1970

TECHNICAL EXHIBITORS

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(representing Med-Chi Insurance Trust)
Executive Consulting Services, Inc.
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GASTROENTEROLOGIC MEDICINE, Moses Paulson, MD; Lea and Febiger, Philadelphia, Pennsylvania, 1969.

The contributors to this book constitute a veritable *Who's Who in Medicine*. Not the least distinguished is the author, a Marylander who has long been active and deeply interested in Faculty affairs.

Dr. Paulson has made a valiant and successful attempt to include in a single comprehensive volume all of the disorders involving the alimentary canal and its accessory organs, the liver, gall bladder and pancreas. The result is a book that has something for almost every physician, whether he is primarily interested in gastroenterology or another specialty. It is especially valuable to the internist, pediatrician and generalist. Exclusive of the index, this book contains over 1,500 pages.

Radiologic and psychologic factors are presented in some detail, including the comparatively new fields of cineradiography, arteriography, percutaneous portography, and splenoportography. Psychiatrists may also be interested, although this area of medicine is presented with the non-psychiatrist in mind.

To mention or discuss in detail the various specific areas covered in different chapters would consume too much space. However, all recent advances and changes in this field have been well covered. The internist's interests have been dovetailed with those of the surgeon, when surgical intervention would appear to be a necessary adjunct to the more conservative treatment by the medical man. While certain areas overlap in content and are perhaps repetitious, this has been done either to present a different view, to attain clarity, or to provide completeness of the specific subject or area. Dermatologists will be particularly interested in the demonstrated evidences which reveal gastroenterologic disorders. With the ease of travel today, with parasitic infestation and infection gaining increased importance, this is extremely valuable.

The index is purposely extensive, so that the reader can easily find reference to any particular area. Dr. Paulson and his collaborators can be proud of the monumental result of their efforts.

CARDIAC ARREST AND RESUSCITATION, Hugh E. Stephenson, Jr., MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This is the third edition of this publication, and, as in previous editions, it attempts the difficult task of accurately portraying the recent advances and techniques, many in ancillary areas, in the field of present-day cardiopulmonary resuscitation. Included in this edition is a concise review of the historical perspective of cardiopulmonary resuscitation, which adds to the readability of the book, making it well worth adding to the medical library shelves of the interested physician.

PLASTIC AND MAXILLOFACIAL TRAUMA SYMPOSIUM, VOLUME I, Nicholas G. Georgiade, DDS, MD, et al; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This is the first in a series of transactions of the trauma symposium, held under the auspices of the Educational Foundation of the American Society of Plastic and Reconstructive Surgeons.

It is intended to define the specialties within the field and to foster cooperative efforts of care in providing for the needs of the patient. It serves these purposes well.

SYMPOSIUM ON CANCER OF THE HEAD AND NECK, Volume II, John C. Gaisford, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

Volume II of this series consists of the proceedings of the Second Annual Symposium of the Educational Foundation of the American Society of Plastic and Reconstructive Surgery held in late 1968.

In the preface, Dr. Gaisford indicates that the topic for this second symposium was chosen because of the commonness with which cancer occurs in this area, and because in many areas of the United States, the proper overall management of cancer of the head and neck "leaves a lot to be desired".

The book covers diagnosis, modern advances for the cure of these tumors, and practical, direct methods for prompt surgical reconstruction of damaged parts. Only the most prestigious individuals were chosen to present papers at this session. A plea is made that ". . . this work be undertaken only by those properly trained". In making this plea, the point is also made that plastic surgeons have "no corner on this market" but rather all disciplines of the profession should join together for the ultimate benefit of the patient.

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MEDIC 1970 SCHEDULE

MARCH 27, 1970 — 12:30 PM

HISTOPLASMOSIS

Henry V. Chase, MD
Department of Medicine
Frederick Memorial Hospital

The early history of histoplasmosis will be discussed and illustrated, with emphasis on those aspects related to Maryland and Virginia. Epidemiological studies will be described and several recent surveys in this area will be mentioned. Available diagnostic tests and methods of treatment will be reviewed.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, March 30, 1970	12:30 PM
	Wednesday, April 1, 1970	9:00 AM
		2:00 PM

APRIL 10, 1970 — 12:30 PM

MALNUTRITION

George C. Graham, MD
Associate Professor of Pediatrics
Professor of International Health
The Johns Hopkins University School of Medicine

Forms of malnutrition exist in all societies. Neither the deprived nor affluent are immune to the ramifications of this disease. Data on and consideration of the problem as it exists today will be presented.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, April 13, 1970	12:30 PM
	Wednesday, April 15, 1970	9:00 AM
		2:00 PM

APRIL 17, 1970 — 12:30 PM

ECTOPIC PREGNANCY

Harold Misenheimer, MD
Associate Chief of Obstetrics and Gynecology
Baltimore City Hospitals

Rafael Garcia, MD
Assistant Chief of Pathology
Baltimore City Hospitals

This presentation will emphasize the salient diagnostic features of ectopic pregnancy. The danger of missing an ectopic pregnancy in diagnosis and the typical pathologic patterns found with an ectopic pregnancy will be discussed.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, April 20, 1970	12:30 PM
	Wednesday, April 22, 1970	9:00 AM
		2:00 PM

APRIL 24, 1970 — 12:30 PM

TUBERCULOSIS AND ATYPICAL MYCOBACTERIA

Edmund G. Beacham, MD
Chief, Tuberculosis Division
Baltimore City Hospitals
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Discussion will be centered on clinical aspects of pulmonary tuberculosis including disease caused by atypical mycobacteria. Comments will cover tuberculin tests, differential diagnosis, and drug treatment.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, April 27, 1970	12:30 PM
	Wednesday, April 29, 1970	9:00 AM
		2:00 PM

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

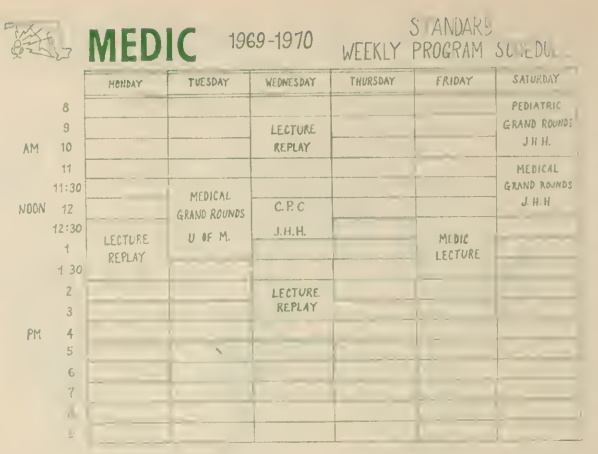
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ARTS AND HOBBY EXHIBIT

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APRIL 1, 2, 3, 1970 The Alcazar, Baltimore

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.....

2. Amount of space required—depth, width, and height: .....

3. Electrical or other requirements: .....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

An Arts and Hobby Exhibit will be held during the 172nd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible. Entries will be accepted until all exhibit space is allotted. Please have exhibits framed or mounted.

Entries should be delivered to The Alcazar, Cathedral and Madison Streets, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, March 31. They must be removed on Friday, April 3, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit.

Certificates will be awarded to the prize-winning exhibits. The names of exhibitors received by February 1, 1970, will be listed in the printed Annual Meeting program. However, all entries should be submitted as early as possible.

Committee for Arts and Hobby Exhibits:

Mrs. Charles H. Williams, *Chairman*
Mrs. George H. Yeager, *Chairman, Judging*
Mrs. Kurt Lederer
Mrs. Marvin I. Mones

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APRIL 1, 2, 3, 1970

A block of rooms has been set aside at the BELVEDERE HOTEL, Baltimore, for those attending this meeting. Because of many activities in the city, rooms will be at a premium.

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Please reserve ..... rooms Approximate rate ..... No. of persons.....

Date of arrival ..... Date of departure .....

Attending Annual Meeting of the Medical and Chirurgical Faculty.
All requests subject to confirmation.

MED-CHI TOUR

The Medical and Chirurgical Faculty is sponsoring another exciting tour in the near future:

ORIENTAL CARNIVAL—May 1 to May 17, 1970

A fabulous deluxe tour leaving from Friendship Airport. This is an all-inclusive tour with six fun-filled days and nights in Tokyo, seven glorious days and nights in Hong Kong, three enchanting days in Honolulu. An opportunity is provided to visit the fabulous 1970 Japan World Exposition in Osaka via the famous "Bullet" train (140 m.p.h.). Included are sightseeing tours, a get-together cocktail party, dinners in restaurants of your choice, breakfasts, and many other attractions.

Make your reservations NOW: For information and reservations contact Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles Street, Baltimore 21201 (301-727-0680) or Mrs. Genevieve Ritchie, the Faculty office, 1211 Cathedral Street, Baltimore 21201 (301-539-0872).

MEDICAL NEWS

Governor Marvin Mandel recently announced that the use of DDT in Maryland has been virtually banned, except in cases where the public health is threatened by epidemic, because of its potential hazards to the health of Maryland citizens and the state's wildlife and waterfowls.

The regulations on DDT were prepared by the State Board of Agriculture, in consultation with the State Department of Health and Mental Hygiene and representatives of the Department of Natural Resources, and the Maryland Agricultural Commission.

In addition to DDT, other chlorinated hydrocarbons and other pesticides whose use is sharply restricted under the new regulations are chlordane, dieldrin, endrin, parathion and methyl parathion. Sodium arsenite is banned completely in Maryland under the order.



Governor Mandel

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J. J. McDonald, MD, S. V. Battiata, MD, and S. Mahallati, MD, have announced the removal of their office for the practice of pediatrics and adolescence to: University Boulevard Medical Center, 831 University Boulevard, East, Suite 27 and 28, Silver Spring.

* * *

In December, by a vote of 88 to 4, the U.S. Senate passed H.R. 13111 appropriating $21 billion for HEW for fiscal 1970. Of that amount, $52.2 million will go to the Health Services and Mental Health Administration for community mental health centers and narcotic addict rehabilitation; $100 million is authorized for Regional Medical Programs of which $25 million is earmarked for development, assistance, and chronic disease control activities; $258 million is allocated for hospital construction; $200 million to the National Cancer Institute; $182 million to the National Heart Institute; $25 million to the National Eye Institute and $160 million for the construction of health education research and library facilities; and $215 million for health manpower.

The bill is currently in the House for concurrence of the Senate amendments.

* * *

Effie O. Ellis, MD, former director of medical education and house pediatrician at Provident Hospital, has been named to the newly created American Medical Association post of Special Assistant for Health Services for E. B. Howard, MD, AMA executive vice president.

Dr. Ellis recently served as chairman of a panel group at the 1969 White House Conference on Food and Nutrition. She has held several federal posts. She is currently the director of maternal and child health for the Ohio State Department of Health.

* * *

Blaine H. Eig, MD, has been re-elected president of the Medical and Dental Staff of Holy Cross Hospital in Silver Spring.

A specialist in internal medicine, Dr. Eig was a member of the organizing committee of physicians who formed the medical staff of Holy Cross Hospital prior to its opening in January 1963.

Elected to serve with Dr. Eig were **Timothy Tehan, MD, vice president; Joseph O'Neil, MD, secretary-treasurer; Albert Modlin, MD, and Richard Pollen, MD, members-at-large of the executive committee.**

Other members of the executive committee are Nicholas Azzato, MD, chairman, department of surgery; Manuel Balsiero, MD, chairman, department of anesthesia; Edward Beeman, MD, chairman, department of medicine; Stanley Wolf, MD, chairman, department of pediatrics; Robert McCullough, MD, chairman, department of pathology; James S. Stanton, MD, chairman of the department of obstetrics and gynecology; Merton White, MD, chairman, department of general practice; Edward Soma, MD, chairman, department of radiology; John P. Haberlin, MD, immediate past president; and Sister Helen Marie, CSC, hospital administrator.

* * *

Joseph S. Hall, an executive with the Model Cities Agency in Baltimore, has been named assistant director of planning for The Johns Hopkins Medical Institutions.

Dr. David E. Price, director of planning at the Medical Institutions said Mr. Hall will take steps to involve community groups in development of facilities and community service programs. He will also provide liaison with other community agencies.

* * *

During a recent meeting of the American Association of Obstetricians and Gynecologists in Hot Springs, Va., **J. Donald Woodruff, MD, Baltimore, was elected assistant secretary of the association.**

* * *

Earl H. Dearborn, MD, a 1949 graduate of The Johns Hopkins University School of Medicine, has been appointed president of the newly constituted Therapeutic Research Division of the Professional Products Group of Miles Laboratories, Inc., of Elkhart, Indiana.

* * *

Orthopedic surgeons at The Johns Hopkins University School of Medicine are reportedly among the first in the country to be treating patients with severe arthritis of the hip by replacing the entire hip with an artificial one. The technique, designed and perfected in Europe, has a success rate of 90% among the 5,000 patients who originally received the artificial hip in Europe.

Some of the benefits of this technique as opposed to an older version requiring fusion of the joint include a shorter hospital stay, less risk for elderly patients, and greater mobility after the recovery period. The first total-hip operation was performed at The Johns Hopkins Hospital in October of last year. Since then, it has been repeated seven times, with one patient receiving two artificial hips. Seventy hip replacements a year are being anticipated by Hopkins surgeons.

Robert Robinson, MD, professor of orthopedic surgery; Lee H. Riley, Jr., MD, associate professor of orthopedic surgery; and Gerald A. M. Finerman, MD, assistant professor of orthopedic surgery traveled to Europe to study the technique of the operation before offering it to patients at Hopkins.

* * *

B. Martin Middleton, MD, has assumed the presidency of the medical staff at St. Agnes Hospital.

As president, Dr. Middleton is chairman of the executive committee which serves as the governing body for St. Agnes' medical staff. In addition to Dr. Middleton, the officers of the medical staff for 1970 include: **Wilmer K. Gallager, Jr., MD, immediate past-president; Stephen K. Padussis, MD, president-elect; and Samuel P. Scalia, MD, secretary-treasurer.**

A native of Waldorf, Dr. Middleton received his BS and MD degrees from the University of Maryland. He served an internship and completed his residency at St. Agnes.

He is a Fellow of the American College of Surgeons and holds membership in the AMA, Southeastern Surgical Congress, and the Baltimore City Medical Society. Dr. Middleton is chairman of the Faculty's Legislative Committee.



Dr. Middleton

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The cooperation of physicians is requested in the referral of **patients with periodic paralysis for a study of new therapeutic agents** being conducted by the National Institute of Neurological Diseases and Stroke at the Clinical Center, National Institutes of Health in Bethesda.

On completion of the studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to the study may write or phone: W. King Engel, MD, Clinical Center, Room 10-D-18, NIH, Bethesda, Md. 20014. (301) 496-6191.

* * *

New Diplomates of the American Board of Anesthesiology as of October 17, 1969 are: **Robert R. Hylton, MD, of Camp Springs; Edward P. Juras, MD, Rockville; Peter B. Kane, MD, Bethesda; Bernhard Laukenmann, Marriottsville; Toshio Sasamori, MD, Baltimore; Allan L. Smith, MD, Bethesda; and Robert K. Stoelting, MD, also of Bethesda.**

* * *

A Cecilton physician has returned to Vietnam for the fifth time to lend his professional services to the wounded and sick civilians under the Volunteer Physicians for Vietnam program of the AMA.

Wayne Foster, MD, is currently serving the 60-day tour with 14 other physicians from across the country.

* * *

Establishment of local sports-medicine councils located within school board areas has been proposed by the American Academy of Pediatrics.

The academy's Committee on Youth urges all national organizations interested in the health status of children and youth participating in sports and recrea-

tional activities "to approve, actively support, and encourage all its membership to develop these councils in every community throughout the United States."

Membership in the sports-medicine council would consist of the school administrator, athletic coach, trainer, physician, and athletes. The council would be primarily responsible for: • evaluating local resources—material and individual—available for the provision of the highest quality of health care of the athlete; • reviewing and implementing established policies of national organizations which are recognized as leaders in health concerns for the athletic participant; • inspecting sports equipment periodically, and calling any deficiencies and substandard equipment to the attention of the appropriate authorities who, in turn, would have the authority to cancel any athletic event until the necessary recommendations have been enacted; • reviewing instances where injury or illness related to sportsmedicine and relating them to the public, local medical societies, school administrators, coaches, trainers, athletes, and others; • and promoting workshops, conferences, and other educational endeavors for the preparation and continuing instruction of those who are responsible for the health and safety of young athletes.

* * *

The Johns Hopkins Hospital and the Baltimore office of the National Alliance of Businessmen have signed a training contract to enable the hospital to hire and train 55 disadvantaged workers from the Baltimore area.

The men and women hired under the contract will be trained for jobs as central supply aides and orderlies. They will be referred to the program by the Maryland State Employment Service and Concentrated Employment Program.

In addition to on-the-job training, the hospital will provide classroom education, special counseling, job coaching, and other services to help the workers stay on the job.

* * *

The cooperation of physicians is requested in the **referral of women for a study of ovarian cancer** being conducted by the Department of Obstetrics and Gynecology at the George Washington University Medical Center, Washington, D.C.

Referrals of women with proven or suspected ovarian cancer are needed. Selected women with a preoperative diagnosis or those with a proven operative diagnosis before radiation therapy or chemotherapy will be studied to determine peritoneal fluid cellular patterns. Attempts at therapy will be made and experimental drugs may be used in conjunction with serial cellular studies.

Physicians interested in having their patients considered for admission to the studies may write or phone: Larry McGowan, MD, Department of Obstetrics and Gynecology, The George Washington University Medical Center, 2150 Pennsylvania Ave., N.W., Washington, D.C. 20037. (202) 331-6357.

* * *

The Carnegie Corporation and the Commonwealth Fund have announced grants to The Johns Hopkins University to develop and demonstrate new systems of community health care which will provide a full range of medical services to thousands of individuals.

The three-year grant, totalling $500,000, will aid in the establishment of the prepaid, comprehensive care program for the residents of Columbia and a similar cooperative venture in East Baltimore, as well as a thorough reorganization of the Johns Hopkins Hospital Outpatient Department to provide specialty clinic backup for the two prepaid care programs, and better primary and specialty care for East Baltimore residents in general.

Within five years, it is anticipated that more than 50,000 individuals will be enrolled in the two prepaid programs. A clinic has been opened and construction begun on a permanent facility in Columbia. Discussions and planning are proceeding with representatives of the East Baltimore community with the hope that the program can begin sometime this year and will include a large clinic removed from the immediate area of the hospital.

* * *

AMA President, Gerald D. Dorman, MD, testified before the Subcommittee on Health of the Senate Labor and Public Welfare Committee in December to urge increased federal support of family planning programs and activities.

Dr. Dorman noted that while there are many existing federal programs of family planning, it is estimated that five million women are still without access to family planning services. He also indicated the urgent need for a greatly expanded program of population research, and for a broad scale public education and information program.

* * *

The new officers of the Allegany County Medical Society are: **Robert Feddis, MD, president; William R. Newman, MD, vice-president; and Nicholas Giarritta, MD, secretary-treasurer.**

The following members of the society were elected as delegates to the Med/Chi House of Delegates: **George Simons, MD, Gina Glick, MD, and Robert J. Dawson, MD.**

* * *

Gary W. Gill, CT (ASCP), chief research associate of the Cytopathology Division of The Johns Hopkins University School of Medicine, has prepared a booklet on "Exfoliative Cytology".

The booklet contains detailed information on the collection and preparation of cytopathological specimens of cerebrospinal fluid, sputum, body cavity fluids, urine, peripheral blood and cells exfoliated from esophageal lesions or the gastric mucosa. The booklet includes instruction in fixation, staining, mounting, and microscopy, plus a bibliography of selected references on exfoliative cytology.

Copies may be obtained, free of charge, from Millipore Corporation, Bedford, Mass. 01730.

* * *

In December, the FDA announced its decision to order recalled from the market oxytetracycline capsules, produced by eight manufacturers, because of FDA's determination that those products are of questionable medical value.

Chas. Pfizer & Co., Inc. first discovered the drug in 1949 and has been manufacturing and distributing the drug throughout the world under the trade name "Terramycin". Since the expiration of the Pfizer patent in 1967, oxytetracycline capsules have been manufactured and distributed in the U.S. by a number of other companies under the generic name and other brand names.

Pfizer initially provided the FDA with the results of its blood level studies on a number of oxytetracycline products. The specific study of blood levels involved in the use of Pfizer's product, Terramycin, have been adopted as the standard by which FDA is judging the other capsules submitted for certification. Pfizer's product has not been withdrawn and is not affected by FDA's action.

This appears to be another instance which emphatically demonstrates that drugs of the same generic name are not necessarily equivalent therapeutically.

* * *

For one week in May, 450 of the brightest young people in the world will gather in Baltimore to exhibit their achievements in science.

The 21st International Science Fair will be held at the Baltimore Civic Center, May 10-15, 1970. Sponsored by the Science Service, the North Baltimore Kiwanis Club, and The Johns Hopkins University, the Fair was created to promote interest among young people in the fields of pure and applied science.

* * *

Modern Medicine has included **Julius Axelrod, PhD,** among its winners of the Journal's Distinguished Achievement Awards for 1970.

Dr. Axelrod, chief of the section of pharmacology, Laboratory of Clinical Science, National Institute of Mental Health, Bethesda, was cited for his research into the effects of drugs on the body and the sympathetic nervous system.

Some of the other Maryland recipients through the years have been: Alfred Blalock, MD—1960; Walter E. Dandy, MD—1935; Nicholson J. Eastman, MD—1959; John E. Howard, MD—1964; Perrin H. Long, MD—1938; Victor A. McKusick, MD—1966; Harvey B. Stone, MD—1934; Helen B. Taussig, MD—1953; and Hugh H. Young, MD—1938.

* * *

The American College of Surgeons has appointed **John D. Young, MD,** of Baltimore, to the Advisory Council on Urology.

* * *

The new president of the American Society for Surgery of the Hand is **Raymond M. Curtis, MD,** of Baltimore.

Dr. Curtis was installed January 15 at the society's annual meeting in Chicago.

He is assistant professor in plastic surgery at The Johns Hopkins University School of Medicine, and is consultant in hand surgery to the Surgeon General of the Army. He is a visiting hand surgeon at the Union Memorial Hospital and the Children's Hospital.



Dr. Curtis

* * *

A major strengthening of Maryland's health services, through the creation of a Directorate for Mental Retardation under the Department of Health and Mental Hygiene, has been announced by Neil Solomon, MD, PhD, secretary of Health and Mental Hygiene.

Dr. Solomon stated that the directorate method of organization would allow for considerable flexibility for future needs. The new organization, placing high priority on services to the retarded, will be headed by a director, who will have equal

stature with the existing commissioners of health, mental hygiene, directors of juvenile services and the comprehensive health planning agency. The activities of the Directorate will encompass institutional care now operated by the Department of Mental Hygiene; community-based care, a Health Department function; liaison with state and local departments of education involved with special education; and research, development, and prevention.

Being shifted to the new Directorate will be Rosewood State Hospital, Henryton State Hospital for adult retardates, and the Maryland Metropolitan Washington Retardation Center (Silver Spring) which will be completed by July.

Under the community-based program, the Directorate will be concerned with: day care and training centers in the state; hospital screening of newborns for treatment and follow-up of phenylketonuria; inspection and licensing of hospitals and residential centers, in cooperation with the Division of Medical Facilities Development; community diagnostic and advisory services for handicapped children, in cooperation with the Division for Crippled Children; provision of special consultation services for the mentally retarded—psychology services, nutrition services, public health nursing, occupational therapy, health education, and social work services.

* * *

HEW Secretary Robert H. Finch has announced that the voluntary medical insurance premium older people pay for Medicare will be $5.30 a month for the 12-month period beginning July 1.

Secretary Finch noted that the present $4 premium rate, set in December 1969, is too low to cover costs during the current premium period and that the special Medical Insurance Trust Fund is now drawing on its reserves.

* * *

On February 8, **Edward P. Radford, MD,** professor of environmental medicine at The Johns Hopkins University School of Hygiene and Public Health, spoke at the Annual Scientific Session of the Maryland Thoracic Society held in Baltimore.

Dr. Radford, featured as the Trudeau Lecturer, spoke on the Medical Aspects of Air Pollution and its Control.

During the session a special panel discussion on Cortico Steroids in Sarcoidosis was held. The moderator was **Carol Johns, MD,** director of the Sarcoid Clinic of The Johns Hopkins University.

* * *

More intensive and long-range research on the dangerous effects of the use of marijuana has been called for by **Neil Solomon, MD, PhD,** the State Secretary of Health and Mental Hygiene.

"For some time I have maintained that all of the facts dealing with the harmful effects of marijuana are not yet in. We need an additional five years of research to determine both the extent of these effects and to what dangers continual use can ultimately lead," he stated.

Dr. Solomon went on to say, "However, to say outright, at this point, that the drug is only psychologically habituating and that there are no serious side effects is wrong. It's an unpredictable drug, used by unpredictable people, which brings about unpredictable reactions."

He also said that more and more frequently young people are using marijuana and abusing it to the extent that in some instances hospitalization is required. He said that smoking of marijuana can produce any number of immediate and physical effects which become progressively stronger to the chronic user. Dr. Solomon added that the effects on the brain pose the greatest problem, since the user may become psychotic.

In addition, he said, "Actually, a sufficient dose of marijuana brings on a state of temporary insanity. If a user is extremely sensitive to it, even a small dose of the drug can cause this reaction, and actions become totally unpredictable. Habitual use leads to increased doses and an even greater psychological dependence."



Dr. Solomon

* * *

A new method of paying for health care services designed to get increased value for the Medicare health care dollar, is being tested in New York city under a contract signed by Robert M. Ball, commissioner of social security, and the Health Insurance Plan of Greater New York (HIP).

One of the major objectives of the three-year experiment is to encourage the use of alternatives to high cost hospital care suitable to each patient's progressive condition.

* * *



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so that she can come to terms
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Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the lutenizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates in the United States found relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives. This has not been confirmed in the United States.



Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for 2 months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: Increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

1. Royal College of General Practitioners: Oral Contraception and Thromboembolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967.
2. Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968.
3. Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969.
4. American Journal of Epidemiology (to be published).

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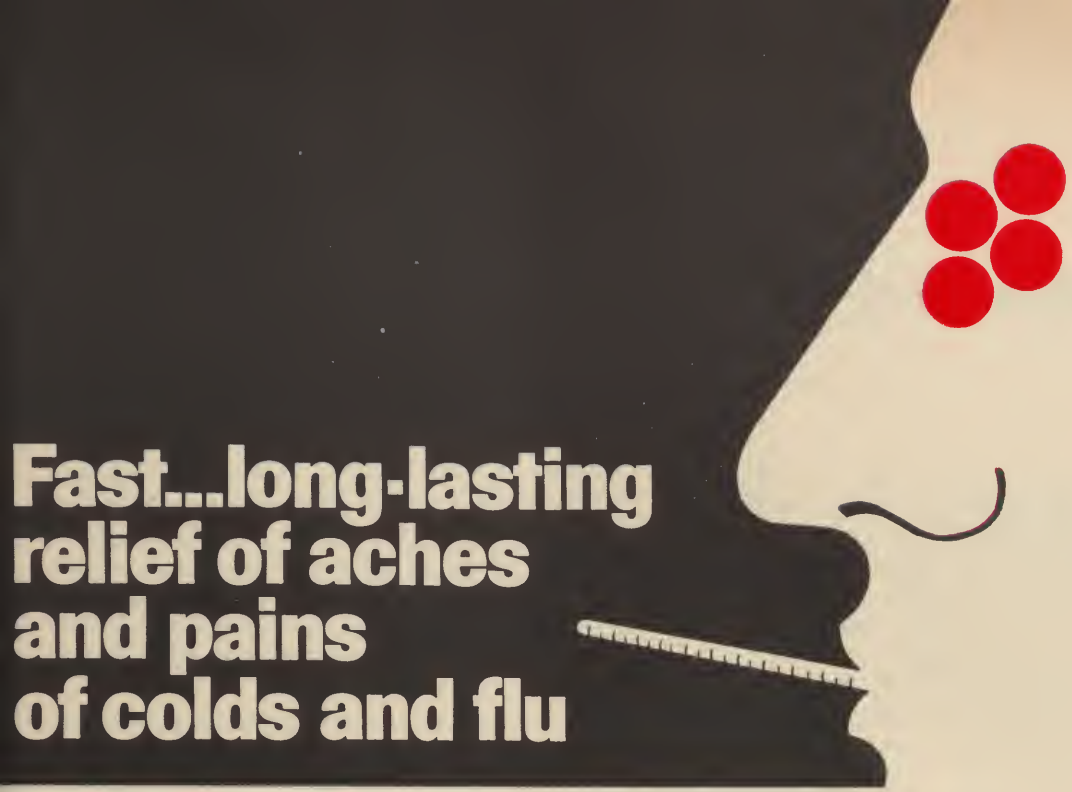


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It would seem that the willing of one's body or any of its organs should be a simple matter. This is particularly so in light of the Uniform Anatomical Gift Act adopted in Maryland in 1968—one of the first states to take such action. However, since its adoption and the initial deluge of requests for appropriate legal forms, interest has waned.

With the development of a uniform card for organ and tissue donation, it seems that most, if not all of the roadblocks toward an individual "giving to the living" have been cleared. The development of such a uniform card was important. Now, when an individual dies in another state, the legality of such a bequest is no longer in question. Uniformity of the law (in 39 states) and uniformity of the legal form itself now makes donation quicker and easier. More important, however, the person should carry the Uniform Donor Card and supplement this with a Medic-Alert ID Tag. Thus, if he should die outside his community, and relatives are not present or aware of the death, prompt identification of the potential donor can be made.

In some cases, organs must be removed within a specified time after death, or their value is impaired. Hospitals and medical personnel are reluctant to move in this direction until the legal right to do so has been clearly established. Without such a donor card and the means to alert hospital or attendants to the fact that the patient is a prospective donor, many organs would be lost to science and the wishes of the donor not carried out.

Public interest in donation can be encouraged.

As a corollary, the agencies below are cooperating in the operation of a Medical Transplant Information Center, with offices at 40 W. Franklin Street, Baltimore, Maryland 21201. Telephone: 539-4355. These agencies are underwriting the expenses of this Center, as well as the maintenance of a Central Registry of donors. The value of this project is being carefully studied in an effort to determine if individual agencies, cooperating in this manner, can stimulate the supply of donations and maintain a ready reference source of information on such donations for the public.

Those wishing to obtain a supply of donor cards should contact:

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of the State of Maryland
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Baltimore, Maryland 21201

National Pituitary Agency
Suite 503-507
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Baltimore, Maryland 21201

Anatomy Board of Maryland
29 S. Greene Street
Baltimore, Maryland 21201

Medical Eye Bank of Maryland
40 W. Franklin Street
Baltimore, Maryland 21201

Kidney Foundation of Maryland
879 Park Avenue
Baltimore, Maryland 21201

John Sargeant

Jejunocolostomy For Obesity

Three cases are presented which show that jejunocolostomies resulted in marked weight losses. A 50 cm segment of jejunum was anastomosed to the transverse colon, bypassing the remainder of the small bowel and the ascending colon. Detailed accounts of these cases demonstrated the severe side effects and numerous postoperative complications. After fifteen, seven, and seven months respectively, the jejunocolostomies were revised to jejuno-ileac shunts. Because the purpose of the paper is to demonstrate the problem involved in the jejunocolostomy, the periods following the revisions are developed briefly. The side effects are such that few patients and physicians would be willing to accept them. Though not discussed in this paper, 108 jejuno-ileostomies have been performed by the author on obese patients, and he finds this operation much more acceptable for both patient and physician.

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Weight losses of 45.4 kg (100 lb) in six to nine months are to be expected with jejunocolostomies in extremely obese patients. However, this is not the whole story. I have often wondered why the number of case reports in medical literature were so few. The largest series reported by I. H. Page, MD, was only 11 cases.[1] J. H. Payne, MD, in his first report in 1963, covered only ten cases. Of these ten, eight underwent additional revisions within a short period of time.[2] Henry Shibata, MD, reported 11 cases.[3] Other reports have generally consisted of only one or two cases,[4-7] and in my discussions with other physicians, frequently I have heard them state that they have performed only one of these operations. After completing only three of them, I believe that I have found the reason for the few number of these operations being performed.

Three extremely obese women had jejunocolostomies for the purpose of weight reduction. All of these patients had had disorders related to obesity that were considered to be major health hazards. The primary operation for all three of these cases was identical. The jejunum was divided 50 cm (20 inches) below the ligament of Treitz. The proximal end of the jejunum was then anastomosed to the transverse colon by an end-to-side anastomosis. The distal end of the jejunum was simply closed upon itself and left as a blind sac.

CASE I

In November 1963, I began treating a 32-year-old white woman whose weight was 103.5 kg (250 lb), and whose height was 222.73 cm (68 inches). Over a period of ten years, she and her physicians had tried many methods of weight reduction, including diets, thyroid tablets, and diet-reducing pills without any success. During this period, she was plagued by a multitude of symptoms including indigestion, abdominal distress, menstrual disorders, fatigue, dysuria, heartburn, insomnia, dizziness, hot flashes, and headaches. She had had only one child. Medication for these disorders gave little relief. Her best treatment consisted of being appointed a foster mother by the state welfare department in which



Case I: November 1963
Weight—250 lb.

Case I: November 1964
Weight—127 lb.

Case I: April 1968
Weight—177 lb.

she cared for a large number of children throughout this period. This relieved many symptoms; however, it did not solve her weight problem. So, in November 1963 a jejuno-transverse colostomy was performed, leaving the patient with 50 cm (20 inches) of functioning jejunum. Preoperatively, her cholesterol was 160 mg/100 ml; total protein, 6.4 gm/100 ml; albumin, 3.9 mg/100 ml; and globulin, 2.5 gm/100 ml. Her hemoglobin was 14 gm/100 ml. Within a few days, she was having eight to ten bowel movements a day. In addition, she became nauseated and experienced gas pains in the abdomen. Symptomatic therapy controlled these to some degree.

One month following her surgery, she developed edema of the legs, and her total protein dropped to 5.69 gm/100 ml. Her albumin was 3.1 gm/100 ml, and her globulin, 2.59 gm/100 ml. A high-protein, salt-free diet, oral diuretics, and the wrapping of the legs with Ace bandages relieved this problem within a few weeks. During this period, if the patient had diarrhea, she was not very nauseated; but if she did not have diarrhea, she felt nauseated. The patient was so emotionally motivated by the loss of weight that she was willing to accept these side effects. By the end of nine months, she had lost 52.21 kg (115 lb), and her bowel movements had reduced to four a day. Twelve months after her surgery, her weight was 57.658 kg (127 lb), and for the next three months, it stabilized between 56.75 kg (125 lb) and 59.02 kg (130 lb). Because the patient was very pleased with the procedure, later experience proved to me that she minimized her side effects. She was so proud of herself that her weight loss, to her, overrode the side effects.

Fifteen months after her original surgery, her shunt was revised by a jejuno-ileostomy using 36 cm (15 inches) of jejunum and 25 cm (10 inches) of terminal ileum. This was done in an effort to further relieve her side effects, and to insure her long-term health. At this time, her hemoglobin was only 10.5 gm/100 ml. In preparation for the second procedure, she was given 1000 ml of whole blood. Since this paper is dealing primarily with the jejuno-colic shunt, the remainder of her history will be briefly stated.

Her weight increased progressively to 83.99 kg (185 lb). During the next twelve months, almost all of her undesirable abdominal complaints disappeared. Nausea and gas were very rare, and she had one to three bowel movements a day. Now, five years after her first operation, her weight fluc-

tuates between 72.64 kg (160 lb) and 86.16 kg (190 lb). Her body proteins and cholesterol remain at normal levels. She feels well and has had very little medical treatment of any kind since her revision surgery.

CASE II

In April 1966, a 46-year-old Negro woman came to me as a patient. Her weight was 103.078 kg (227 lb), and her height was 165.10 cm (65 inches). This patient had a very low socioeconomic and educational background. She had been known to be a diabetic for five years, but had not had any complications. When prodded about staying on a diabetic diet and losing weight, she simply smiled. She had a multitude of symptoms, including a feeling of dizziness upon waking at night, pains in the chest, pain in the left knee, swelling in the ankles, dysuria, incomplete emptying of the bladder, indigestion, and others.

In the same month, a jejuno-transverse colostomy was performed, leaving the patient with 50 cm (20 inches) of jejunum. Preoperatively, her cholesterol was 262 mg/100 ml; her total protein, 7.9 gm/100 ml; her albumin, 4.6 gm/100 ml; her globulin, 3.3 gm/100 ml; and her fasting blood sugar, 146 mg/100 ml. Within a few days, she was having six to eight bowel movements a day. On the seventh postoperative day, she was dismissed from the hospital. Three months later, she had lost 19.976 kg (44 lb), and in general, was completely miserable. She had a very sad, depressed appearance. She stated that she was so weak that she could hardly walk. She was unable to eat due to continuous nausea, and she continued to have six to eight bowel movements a day. Her general examination looked considerably better than the impression gained through talking with the patient. Her hemoglobin was 12 gm/100 ml; serum calcium, 4.7 mEq/100 ml; cholesterol, 75 mg/100 ml; potassium, 4 mEq/100 ml; total protein, 6.2 gm/100 ml; albumin, 3.5 gm/100 ml; and globulin, 2.7 gm/100 ml. Her glucose-tolerance test reached only 127 mg/100 ml at its highest point. She was treated for four days in the hospital with vitamin B-12, 50% magnesium sulfate, intramuscularly; diphenoxylate hydrochloride with atropine sulfate (*Lomotil*); glucose with electrolytes, and antibiotics for an abscessed tooth. When

Case II: April 1966
Weight—227 lb.



Case II: November 1966
Weight—127 lb.



discharged from the hospital, her general condition appeared excellent. Following this admission, the patient was seen weekly in the office, and received much symptomatic treatment to relieve the growing list of complaints, including insomnia, loss of appetite, pains in the chest, diarrhea, coldness and weakness in the extremities, and gas on the stomach. She stated, "If I do not eat, I only have three to four bowel movements a day; if I do eat, I may have as many as ten to fifteen."

Five months after the operation, she suddenly became worse, and seemed to be out of her head. When she talked, she did not make sense. She made a grunting noise, and appeared to be acutely ill. By this time, she had lost 24.97 kg (55 lb); her physical condition appeared good, but her mental state did not seem so good. Her hemoglobin had dropped to 10.6 gm/100 ml; her electrolyte studies were balanced. She was given glucose, electrolyte solutions, and sedatives intravenously. Her cholesterol was 92 mg/100 ml; total protein, 6 gm/100 ml; albumin, 3.4 gm/100 ml; and globulin, 2.6 gm/100 ml. After four days of this treatment, she was feeling well and smiling again. She was again followed as an outpatient, and continued to have many of her same previous symptoms. Six months after her surgery, she developed this peculiar behavior again. She seemed disoriented, and attempted to bite anyone who might be nearby. By this time, she had lost 39.044 kg (86 lb). Electrolyte studies obtained before any treatment were within normal range. An attempt was made to relieve the symptoms with no treatment other than sedatives and time. Her mental state did improve, although she continued to feel very badly until she was given large doses of electrolytes and fluids intravenously. Her cholesterol was 64 mg/100 ml; total protein, 6.1 gm/100 ml; albumin, 3.6 gm/100 ml; globulin, 2.5 gm/100 ml; and hemoglobin, 9.8 gm/100 ml. After six days, she was rejuvenated and smiling. Outpatient treatment continued in the same fashion for one more month. She had lost a total of 45.4 kg (100 lb) in seven months, and she showed no evidence of slowing down in her weight loss.

Due to all of the factors involved, I felt that it was necessary to revise her intestinal bypass. On November 28, 1966, the jejunocolostomy was taken down and a jejuno-ileostomy was performed, leaving the patient 33 cm (13 inches) of jejunum and 10 cm (4 inches) of terminal ileum. It was noted at this time, and demonstrated by the biopsies, that the functioning jejunum had hypertrophied in its wall, and that there was muscular atrophy in the wall of the defunctionalized ileum. It was also noted that the 50 cm (20 inches) that were measured at the time of her original surgery had been reduced to 33 cm (13 inches). At the time of this surgery, she was given 1000 ml of whole blood. Her cholesterol was 76 mg/100 ml; total protein, 6.2 gm/100 ml; albumin, 3.45 gm/100 ml; and globulin, 2.75 gm/100 ml. A biopsy of the liver was taken, with a pathological report of fatty metamorphosis.

Following her revision, the patient did exceedingly well. All of the symptoms attributable to the jejunocolostomy disappeared; however, she continues to have two large bowel movements a day. Twenty-four months after her revision, her weight has slowly increased to the present weight of 67.192 kg (148 lb). She is happy and well.

CASE III

In August 1967, I accepted a 39-year-old white woman as a patient. Her weight was 178.876 kg (394 lb), and her height, 167.64 cm (66 inches). Previously, she had had two Caesarean sections and a ventral hernia repair, which broke down. Since her last pregnancy in 1962, she had been known to have diabetes. Following an episode of polio in 1956, her weight climbed to 200.668 kg (442 lb). In 1962, she reduced to 131.66 kg (290 lb) through the use of thyroid tablets, pituitary shots, and diets; however, this quickly increased to the range of 158.90 kg (350 lb) to 181.60 kg (400 lb). She stayed within this range, in spite of the use of diets and pills. She stated, "I lost 40 pounds, and then gained back 60 pounds." She complained of chronic fatigue, cramps and swelling in her legs; she stated that the weight of her abdomen strained her back. Preoperatively, her cholesterol was 259 mg/100 ml; total protein, 6.6 gm/100 ml; albumin, 3.7 gm/100 ml; and globulin, 2.9 gm/100 ml. Her glucose-tolerance test reached a peak at 238 mg/100 ml. At the time of her operation in August 1967, gallstones were found, and her gall bladder was removed. At the same time, a jejunocolostomy was performed, using 90.8 cm (20 inches) of jejunum. The ventral hernia was also repaired with the use of Merseline plastic mesh. Within a few days, she was having ten to twelve bowel movements a day. Two weeks later, necrosis developed in the patient at the lower edge of her incision, and the edges began to separate. In addition, superficial phlebitis in the anterior lateral parts of both thighs appeared.

Three weeks after surgery, a general debridement and secondary closure of her incision was performed. In doing this, a section of skin, 40 cm (16 inches) in length, and as wide as 10 cm (4 inches) in some parts, was excised. She was given 1000 ml of whole blood and treated with antibiotics. The incision healed very slowly. After a total of 40 days in the hospital, she was allowed to go home. She complained considerably of nausea and weakness, and had three to four bowel movements a day. She became depressed and wanted to have the operation revised to establish normal intestinal continuity. Two months after her surgery, she had lost 31.78 kg (70 lb), and was back in the hospital in

an effort to relieve the cause of her complaints. Her cholesterol was 108 mg/100 ml; fasting blood sugar, 85 mg/100 ml; potassium, 2.5 mEq/100 ml; total protein, 5.5 gm/100 ml; albumin, 2 gm/100 ml; and globulin, 3.5 gm/100 ml. She was treated with electrolytes and fluids given intravenously, and was ready to go home again after a week. Three weeks later, she was back in the hospital, complaining of weakness, nausea, and the inability to eat. She was nervous, and felt as if she wanted to climb the walls. She began to have crying spells, but did not know why she cried. She was fidgety and could not sleep, in spite of as much as 6 grains of secobarbital (*Seconal*) at night. Her hemoglobin was only 8.5 gm/100 ml. She had a positive urine culture for proteus vulgarius. Her calcium was 4.1 mEq/100 ml; potassium, 3.1 mEq/100 ml; total protein, 4.7 gm/100 ml; albumin, 1.75 gm/100 ml; and globulin, 2.95 gm/100 ml. By this time, she had lost 38.85 kg (88 lb). The urinary tract infection proved to be chronic pyelonephritis. She was again treated with blood transfusions, electrolytes, antibiotics, and fluids given intravenously. After ten days in the hospital, she returned home.

This period at home lasted for approximately one month, during which she developed severe rectal itching. By this time, she had lost 48.12 kg (106 lb). Her total protein was 5.5 gm/100 ml; albumin, 2.7 gm/100 ml; globulin, 3.2 gm/100 ml; calcium, 4.2 mEq/100 ml; and potassium, 2.7 mEq/100 ml. A heavy vaginal discharge was found to be due to Trichomonas vaginalis. This was successfully treated with diiodohydroxyquin compound (*Floraquin* vaginal suppositories). Sigmoidoscopic examination revealed large internal hemorrhoids, and symptomatic treatment for the rectum was given. Again, she went home after 11 days in the hospital. The rectal itching and hemorrhoids continued to disturb the patient greatly, and much of the itching became painful. Three weeks later, she was admitted to the hospital for a hemorrhoidectomy. At her request, a large area of redundant skin and subcutaneous tissue 45 cm (18 inches) long, 20 cm (8 inches) wide, and 7½ cm (3 inches) deep was excised from the right side of the abdominal wall. Following this surgery, her hemoglobin was only 10.1 gm/100 ml, and she was given 1000 ml of whole blood. It was also noted that, despite repeated treatment, the urine culture continued to be positive. Following her hemorrhoidectomy, she had very little rectal control, even though a sphincterotomy had not been performed. This, along with continual diarrhea, left her in a generally unhappy state. Nevertheless, she was pleased with her weight loss, which at this time was 53.57 kg (118 lb). After 24 days in the hospital she was discharged.

She returned to the hospital in a week, complaining that she had no appetite and was not eating.

Case III: August 1967
Weight—394 lb.

Case III: March 1968
Weight—270 lb.



Every time that she did eat, she had diarrhea, soiling so many of her clothes that everyone in her home was very unhappy with the situation. Again she was treated with sedatives and fluids given intravenously. At this time, the patient and I felt that it was time to revise her bypass to a jejuno-ileostomy. Her weight had dropped to 122.58 kg (270 lb), with a total weight loss of 56.30 kg (124 lb) in seven months. On March 25, 1968, her jejuno-transverse colostomy was taken down and her bypass was revised to a jejuno-ileostomy, leaving her with 35 cm (14 inches) of jejunum and 10 cm (4 inches) of terminal ileum. It was noted that the segment of jejunum that had been previously measured at 50 cm (20 inches) was only 40 cm (16 inches) in length. A liver biopsy was performed, with a pathological report of fatty metamorphosis. Preoperatively, her total protein was 4.4 gm/100 ml; albumin, 1.7 gm/100 ml; and globulin, 2.7 gm/100 ml. She was also given 500 ml of plasma and 1500 ml of whole blood, during the first few days following her surgery. She did exceptionally well, having only two to three bowel movements a day with good bowel control. Within a few days, she was not taking any sedatives. Plans were made for her discharge from the hospital on the tenth postoperative day; however, on the ninth postoperative day, she suddenly developed a massive pulmonary embolus, and died in spite of resuscitative efforts. An autopsy revealed the pulmonary embolus and both chronic and acute pyelonephritis. This patient spent a total of 126 days in the hospital during a period of about 7½ months. During this time, she received a total of 6000 ml of blood.

Metabolic Effects

All of these patients developed anemia to some extent. The first two received only 1000 ml of whole blood; however, the third patient received 6000 ml of whole blood. This anemia in the third case could have been caused partially by chronic pyelonephritis. Preoperatively the cholesterol in all three cases was near the normal level, and following the jejunocolostomy, had a marked drop to levels between 60 mg/100 ml and 110 mg/100 ml. All three cases had normal values of serum protein before operation, and all three dropped to below normal levels after the surgery. In Case I and Case II, this drop was equally divided between albumin and globulin. In Case III, most of the drop was in the albumin fraction, which was reversing the A/G ratio. Cases II and III had mild diabetic curves before surgery. Case II had a normal flat glucose-tolerance test following her surgery. Case III had low normal fasting blood sugars postoperatively.

Complications

Case I. Protein deficiency and anemia.

Case II. Protein deficiency, anemia, and psychotic episodes.

Case III. Wound infection, acute thrombophlebitis, calcium and potassium deficiencies, protein deficiency, anemia, depression, thrombosed hemorrhoids, acute and chronic pyelonephritis, rectal incontinence, and pulmonary embolus.

Conclusions

1. Patients will lose weight drastically with the jejunocolostomy;

2. Mild to moderate nutritional deficiencies will result frequently;

3. Side effects are such that very few physicians and patients will be willing to accept them;

4. Jejuno-ileac shunts are much more acceptable to both patient and physician than the jejunocolostomy. Although jejuno-ileac shunts have not been discussed in this paper, the author has had experience with 108 of these cases.

REFERENCES

1. Page, I. H.: Effects of Jejuno-colic Shunt for Obesity, Serum Lipoprotein, Lipids, and Electrolytes, *Archives of Internal Medicine* **117**:4-16, 1966.
2. Payne, J. H.: Metabolic Observations in Patients With Jejuno-colic Shunts, *American Journal of Surgery* **106**:273, 1963.
3. Shibata, Henry R.; Mackenzie, M. D.; and Long, Richard C.: Metabolic Effects of Controlled Jejuno-colic By-pass, *Archives of Surgery* **95**:413-438, 1967.
4. DeMuth, W. E., Jr., and Rottenstein, H. S.: Death Associated With Hypocalcemia After Small Bowel Short-circuiting, *New England Journal of Medicine* **270**:1239, 1964.
5. Medical Grand Rounds, The Methodist Hospital, Houston, Texas: Obesity: Medical and Surgical Management, Daniel Jackson, and Lynn A. Bernard (eds.), *Medical Records and Annals*, Vol. 60, No. 4, 1967.
6. Sherman, C. D., Jr.: Clinical and Metabolic Studies Following By-passing For Obesity, *Annual New York Academy of Sciences* **131**:614-622, 1965.
7. Bondar, George F., and Priesley: Complications of Small Intestinal Short-circuiting for Obesity, *Archives of Surgery* **94**: 707-716, 1967.

Surgical Grand Rounds

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The following Surgical Grand Rounds were presented at the Med-Chi Annual Meeting in April 1969. George D. Zuidema, MD, Professor of Surgery and Chairman of the Department at The Johns Hopkins University School of Medicine, served as moderator.

Case 1

Dr. Zuidema: We would like to present, for your consideration, four separate clinical cases. Each case will be presented by one of our assistant residents and will be discussed by a member of our staff. The first case concerns a patient with carcinoma of the lung. The case will be presented by Dr. Bertram Zarins and will be discussed by Dr. Robinson Baker.

Dr. Zarins: A 57-year-old Peruvian businessman was admitted to The Johns Hopkins Hospital in December 1968 for evaluation of a chest mass noted on routine examination several weeks earlier. The present illness was discovered when the patient consulted his local physician in Lima, Peru for headaches he had been having for the past four years. A chest X-ray was taken which revealed a mass in the right lung. He was referred to The Johns Hopkins Hospital for further evaluation and treatment.

His symptoms on admission to the hospital included headaches, vague chest discomfort, intermittent paresthesias in the right ulnar distribution, and a chronic morning cough which produced yellow sputum. He had been smoking two packs of cigarettes a day for the past 14 years.

His past medical history included treatment by gastrojejunostomy for peptic ulcer disease 30 years ago and treatment by a hemigastrectomy 15 years ago.

Results of a physical examination on admission were relatively normal. Chest X-ray showed a right paratracheal mass extending into the right upper lobe posteriorly. Sputum cytology was positive for a poorly differentiated adenocarcinoma. Pulmonary function tests revealed a forced vital capacity of 87% and an FEV-1 of 82%. The neurological workup for metastatic disease was negative. A right scalene node biopsy was done and this was negative for metastasis. Thus, with a presumptive diagnosis of carcinoma of the right upper lobe, a posterolateral thoracotomy was performed. This revealed a tumor of the right upper lobe involving the right upper lobe bronchus. A right upper lobectomy was performed. The histologic diagnosis was bronchiolar carcinoma with clear margins; vascular invasion was evident.

The patient developed atrial fibrillation on the second postoperative day with an atrial rate of 400 and a 2:1 block. This was treated with digitalis, xylocaine and quinidine, and his rhythm reverted to normal on the fifth day. The remainder of his postoperative course was uneventful. The patient was discharged two weeks postoperatively and returned to Peru.

Radiology and Pathology Reports

Dr. Goldenberg: A single frontal view of the chest showed a soft tissue mass in the right paratracheal and superior area of the right hilum. There was no calcification in the mass. On the lateral film, this mass could be seen to extend into the posterior aspect of the right upper lobe. In summary, the X-ray revealed a soft tissue mass which is most likely carcinoma.

Dr. Bieseker: We received in the laboratory a right upper lobe. Extending to within approximately 1 cm of the bronchial margins was a 6 cm mass. On section, this mass was quite firm and somewhat gelatinous. The tumor mass extended toward the periphery of the lung, but it was difficult to tell exactly how close it was to the periphery because it was associated with a large amount of atelectasis. The bronchial margin was negative. There was one large parabronchial lymph node present.

The cytologic smears revealed several poorly differentiated cells. There were strings of mucous and many polymorphonuclear cells interspersed within the cancer cells. The tumor cells were characterized by large hyperchromatic nuclei with a large dimple in one side of the nucleus. The clumped chromatin and vacuoles within the cytoplasm are also characteristic of poorly differentiated carcinoma. Thus, the cytologic diagnosis of a poorly differentiated adenocarcinoma was made.

The next section showed a typical bronchiolar carcinoma with the alveoli preserved but lined with anaplastic cells. There was a moderate amount of mucous production and most of the cytoplasm of these cells was filled with mucous showing the typical picture of a moderately anaplastic bronchiolar carcinoma. A higher power view of the specimen showed multiple cells with mitotic figures which also exhibit other characteristics of malignancy, such as pleomorphism, and large irregular nuclei.

In many areas of the tumor, there was evidence of vascular invasion. The wall of both arteries and veins were invaded and on several sections, anaplastic cells similar to the cells seen in the primary tumor were noted within the lumen of smaller arteries and veins.

The large peribronchial lymph node was also sectioned, and under the microscope, pleomorphic anaplastic cells lining the subcapsular sinuses of the lymph node were visible.

In summary, the tumor, a bronchiolar carcinoma which is moderately well differentiated in some areas but quite anaplastic in other areas, is producing a large amount of mucous. The aggressive potential of the tumor is demonstrated by its ability to invade vascular spaces and also to metastasize to the regional lymph nodes.

Discussion

Dr. Baker: Carcinoma of the lung is the most common malignancy in males today. It causes approximately 300 deaths in the United States per day. Surgery offers the best chance of cure, but only one third of those patients admitted to a large general hospital are candidates for surgical excision. I intend to discuss the evaluation of a patient with a potential carcinoma of the lung.

We have tried to develop a method of accurately working up these patients which can be accomplished as rapidly and inexpensively as possible. The first thing is to establish a tissue diagnosis. The cheapest and simplest way for the patient is by cytology. If this is not effective, we then proceed to bronchoscopy and, at the same time, ask the bronchoscopist to biopsy the carina to establish the local extent of the tumor, as well as to establish the histologic type.

If the cytologic and bronchoscopic studies are negative, we then proceed with a scalene node biopsy with a tumor of this size. For a smaller coin lesion, ie, a circumscribed mass less than 5 cm in diameter, a scalene node biopsy has not proved to be of great use since the results are almost routinely negative.

Once the histologic diagnosis is established, we like to determine, if possible, the presence and extent of mediastinal spread. The first method is by history. If the patient has any evidence of hoarseness, this indicates that one of the recurrent laryngeal nerves is paralyzed and we try to confirm this by direct laryngoscopy. The next step is to try to determine if the phrenic nerve and the esophagus are involved by the tumor mass. Chest fluoroscopy and a barium swallow are the most accurate means of determining

either phrenic nerve paralysis or direct invasion of the esophagus.

We then proceed with bronchoscopy if it has not already been done as part of the original workup for a tissue diagnosis. The bronchoscopy is performed to establish the extent of local spread of the tumor along the main stem bronchus.

A relatively new technique, azygous venography, has proved to be useful in evaluating the extent of mediastinal involvement by large tumors near the hilum on the right side. Thus far in our experience, if the azygous vein is blocked this indicates inoperability. Exploration of the mediastinum is the last step to be included. It is not necessary in a large number of cases but is indicated in some selected cases. The mediastinum can be explored by a variety of methods. Probably the most popular is mediastinoscopy, accomplished by a small incision at the base of the neck which is extended through the strap muscles to the trachea. Dissection is carried out along the trachea and it is then possible to introduce a modified laryngoscope or mediastinoscope to visualize various structures within the mediastinum. Perhaps the best method of exploring the mediastinum is a short anterior incision into the side of the chest involved. This is the safest and most diagnostic test. In our experience, it can be accomplished without morbidity and allows a much better mediastinal exploration than can be accomplished by mediastinoscopy.

Once we have satisfied ourselves that there is no local extension into the mediastinum, we then proceed with diagnostic studies designed to determine the presence of distant metastasis. I think our experience and that of a number of other centers has shown that routine scalene node biopsy is not indicated. Of course, scalene node biopsy is indicated if a node is palpable. It is also indicated if you establish a cytologic or histologic diagnosis of an oat cell carcinoma. Such patients have the lowest chance of cure and the highest incidence of metastatic spread to the scalene nodes. But in other cases such as a squamous cell carcinoma, adenocarcinoma, or bronchiolar carcinoma, routine scalene node biopsy in the absence of palpable nodes is not indicated if the lesion is less than 5 cm in diameter. We like to screen the liver for metastatic disease by obtaining an alkaline phosphatase and BSP. If either of these is abnormal, we then proceed with a scintiscan of the liver.

Routine bone surveys and brain scans are not indicated. We only proceed with a brain scan, bone survey, or strontium scan of the bone if these show clinical signs that lesions might be present. In this particular patient, a brain scan was performed because of his history of headaches. This was interpreted as normal.

Once we are satisfied that there is no evidence of distant metastasis, we proceed with some pulmonary function studies. These pulmonary function studies can be very simple. The patient who has no symptoms of respiratory insufficiency, who can walk up two flights of stairs without difficulty really needs no pulmonary function studies. Although we have routinely performed a vital capacity test and measured how much air he can get out in the first second, this is probably not necessary if he has no evidence of obstructive airway disease on physical examination. If these tests are normal, we then proceed with a thoracotomy.

If the patient does have any symptoms of pulmonary insufficiency, or on physical examination shows evidence of obstructive airway disease, we then proceed with more sophisticated pulmonary function studies. Diffusion defects are perhaps best measured by carbon monoxide studies; perfusion defects are measured by quantitative pulmonary scintiscans. Differential bronchospirometry has been abandoned in our institution as a routine procedure.

This diagnostic workup is performed to determine if there are any specific contraindications to thoracotomy. The first contraindication to thoracotomy is local extension of the tumor as evidenced by a positive carinal biopsy. Mediastinal extension as detected by recurrent nerve palsy or perhaps phrenic nerve palsy, is another sign of inoperability. Superior vena caval obstruction is certainly a contraindication. Esophageal invasion or direct extension of the tumor into the mediastinum, as evidenced by exploration of the mediastinum, are also specific contraindications, as is obstruction of the azygous vein. Pleural extension as shown by a bloody pleural effusion or cytologically positive pleural effusion is another indication that the tumor has extended beyond the scope of surgical resection. The presence of distant metastases as indicated by a positive scalene node biopsy, or the presence of metastatic disease in the liver, bones, or brain are also specific contraindications.

Case 2

Dr. Zuidema: The second case deals with a patient with a hiatal hernia. The case will be presented by Dr. Mark Orringer.

Dr. Orringer: This was the first Johns Hopkins Hospital admission for a 46-year-old white male shoe factory worker, who was admitted to the surgical service of Dr. David Skinner for evaluation of his abdominal pain after eating, especially when assuming the recumbent position, a problem which had occurred for approximately two years.

The past medical history is significant only in that the patient was admitted to a veteran's hospital for what he termed a rapid heart rate which subsided spontaneously, required no treatment, and was resolved without any sequela. The patient's family history revealed arteriosclerotic heart disease in both parents, peptic ulcer disease and some form of

intra-abdominal malignancy in two siblings. The social history was also significant: The patient used neither alcohol nor cigarettes.

The history of present illness dated back two years prior to admission when the patient first began to experience left upper quadrant and epigastric dull aching pain after eating, especially when lying down or leaning far forward. This was also accompanied by regurgitation, eructations, and substernal burning. These symptoms progressed in severity and finally, two months prior to admission, he consulted his local physician who advised an upper GI series. This study demonstrated no evidence of an ulcer, but uncovered a hiatal hernia. As a result, the patient was placed on a regimen of antacids and was elevated at the head of his bed. However, his symptoms did not subside and in fact grew worse until, at the point when he was referred to our center for evaluation, he was experiencing almost nightly insomnia from the frequency of his regurgitation.

The patient gave no history of fatty food intolerance, jaundice, or dark-colored urine or acholic stools. He had never experienced hematemasis or melana. His bowel movements had been regular and his weight had remained constant throughout.

On physical examination the only pertinent finding was limited to the abdomen, which was obese with the left upper quandrant and epigastric tenderness to depalpation without rebound or guarding. The bowel sounds were normal and active. Rectal examination was normal, and there were no masses or tenderness. Stool guaiac was negative. Admission laboratory studies included a hematocrit of 42%, and normal white blood cell count, urinalysis, chest film, electrocardiogram, electrolytes, and liver function tests.

The preoperative evaluation of this patient's hiatal hernia was centered around four main studies. The first of these was an acid-barium esophagogram. This demonstrated normal esophageal motility with conventional barium. However, a sliding hiatal hernia with reflux was clearly demonstrated. Upon the administration of acid-barium, there was marked disturbance of esophageal motility with segmental spasm and pooling of barium within the esophagus. This reversed back to normal motility after antiacids were administered and the study was repeated with conventional barium.

The second study performed was esophagoscopy. This demonstrated a patulous cardia with free reflux and no gross evidence of esophagitis. This impression was borne out by biopsy of the esophagus at a point 5 cm above the gastroesophageal junction, which was also negative for esophagitis.

The third group of tests are combined under the term "esophageal reflux tests". Here there was no evidence of a high pressure zone in the lower esophagus on pulling back the pressure recording tube from the stomach into the esophagus. There was evidence of reflux on the pH withdrawal or Tuttle test, as pulling back the pH probe from the stomach where a pH recording of 1.9 was found; into the esophagus 5 cm into the chest still gave a pH reading of 2.1. And this low reading persisted for at least 20 cm up into the esophagus. Finally, the acid clearing test demonstrated that the patient was unable to clear acid well from his esophagus. With repeated swallows, he was only able to lower the pH to a range of 3.

The final test performed was a Bernstein perfusion test where perfusion of the esophagus with saline caused no symptoms. Perfusion with one-tenth normal hydrochloric acid produced retrosternal burning and symptoms similar to those that the patient had experienced. Reinfusion with saline brought alleviation of these symptoms.

As a result of these studies, the patient was taken to the general operating room with a diagnosis of symptomatic hiatal hernia with reflux. Through a left thoracotomy, the cardia of the stomach was reconstructed. The postoperative course was complicated by one episode of paroxysmal atrial tachycardia which responded to digitalis, and with some right lower lobe atelectasis which responded to vigorous cough therapy and postural drainage.

Prior to discharging the patient, several of the studies which the patient had had preoperatively were repeated, including a postoperative acid-barium esophagogram. This still showed that there was some motility disturbance with acid barium, but it must be remembered that this was done only nine days postoperatively. The significant point was that there was no longer a hiatal hernia or reflux demonstrated. A repeat of the acid clearance test and the Bernstein test was still slightly positive, although less so than preoperatively. The pressure recording postoperatively clearly demonstrated that there was a lower esophageal sphincter present. This relaxed on swallowing. So, there was a clear sphincter mechanism in the lower esophagus that had not been present preoperatively. PH electrode withdrawal from the stomach and pH monitoring in the esophagus demonstrated no evidence of gastroesophageal reflux.

Dr. Goldenberg (in discussing the radiological findings): X-rays showed a hiatal hernia above the diaphragm, with some reflux of barium from below the diaphragm to above the diaphragm.

Acid was administered causing reflux and a sensitive esophagus that responded to the acid with unusual spastic contractions. In the initial swallows with neutral barium, there was a smooth peristaltic wave. However, the primary peristaltic wave was disorganized.

The administering of antiacid produced a smooth peristaltic wave similar to the initial swallow with neutral barium.

Management

Dr. Skinner: This patient obviously had an extensive workup, but for good reason, I think. The problem of hiatal hernia is a very common one and it is becoming increasingly more important to sort out those patients with a pathologically significant hernia from those whose hernia is just a normal variant in the general population. In the radiological literature, it is reported that 10% to 60% of upper GI series reveal a hiatal hernia, so that the presence of a hernia by itself is relatively insignificant. Therefore, we have become increasingly concerned with putting the patients with a hernia into separate categories of those with reflux and those without because the essence of this problem is gastroesophageal reflux which causes such complications as esophagitis, aspiration, bleeding, and stricture formation.

Accordingly, we have gone to considerable lengths to develop tests to diagnose reflux as opposed to hiatal hernia, and to try and measure the amount of reflux. These tests will be used as a guide in administering surgical or medical therapy, or in judging the results of the treatment, whether it be surgical or medical. I would like to discuss a few of the details of the tests that were performed on this patient, the conditions indicating surgery, and the results of surgery using the type of procedure that was performed in this case.

The esophageal reflux tests use a pressure-monitoring tube in the lumen of the esophagus and a pH electrode that is passed into the stomach and withdrawn into the esophagus. In normal people we can identify a lower esophageal sphincter manifest by an increased resting pressure. We then pass a pH electrode and measure the gastroesophageal pH gradient which should be very sharp with a rise in pH from one to five or six over a 1 cm distance at the cardia. This patient had no gradient whatsoever. We then put a standard 3 oz of 0.1 N HCl into the stomach, position the pH electrode above the sphincter, and monitor the reflux by pH recordings in the esophagus, while the patient performs a variety of maneuvers.

A tracing of a normal lower esophageal sphincter shows intragastric resting pressure and a rise in pressure as the tube passes through a high pressure zone, and then a drop to the negative intrathoracic environment. This high pressure barrier between the stomach and esophagus somehow prevents reflux. In the patient's tracing, this was perfectly flat with no rise at all before dropping in the thorax; so there was no evidence of sphincter function preoperatively.

We consider a drop in pH at the thorax to be indicative of significant gastroesophageal reflux. Reflux is measured by the number of drops in pH and the persistence of low pH in the esophagus. This patient's pH stayed in the acid range throughout the entire study. Multiple drops in pH indicate an abnormality of the cardia which commonly occurs with hiatal hernia, but may occur in the absence of hiatal hernia.

We have found that people who are in danger of developing complications from their reflux will have abnormal clearing of acid from the esophagus. If we put 15 cc of hydrochloric acid in the mid-esophagus and ask the patient to swallow, the normal patient will raise his esophageal pH progressively with each swallow in a step-like fashion and bring the intraesophageal pH from one to five or six in less than ten swallows. This patient took more than 20 swallows before we stopped the test, as he had no rise in pH at all. We feel that the prolonged persistence of acid material in the esophagus contributes to the likelihood of esophagitis and further contributes to the risk of developing the complications of esophagitis, stricture, bleeding, or aspiration.

Severe symptoms which have not been controlled by medical therapy are the most common indication for surgery, and this was the case with our patient. In addition, patients who have esophagitis to the extent of ulcer formation or bleeding should be operated upon promptly, since there is some risk of developing stricture. Patients with aspiration into the lungs should be operated upon to control their reflux. The operation should be designed to control as many of the various theoretical mechanisms as possible that control reflux. So the operation which can be performed either transthoracically or transabdominally preserves the intrinsic sphincter or restores it. In this patient's case, the surgery created an intra-abdominal segment of esophagus, exaggerated a gastroesophageal angle, reapproximated the diaphragm, and preserved the vagal nerve function.

The type of operation performed was the Mark IV procedure proposed by Ronald Belsey of Bristol, England. The results of hiatal hernia repair in a series which was reviewed several years ago indicate that if we combine mortality, known recurrences (either symptomatic or asymptomatic), poor symptomatic results without evidence of recurrence, and patients lost to followup, and label this entire group as failures of surgery, 85% of the patients known to have anatomic and symptomatic correction of their reflux are not included. This type of surgery is then classified with the same general level of success as we would expect to find in patients receiving surgery for ulcer disease and other benign gastrointestinal conditions.

This patient's acid reflux test postoperatively was completely normal, and his acid clearing maneuver had returned to normal. However, he still showed some sensitivity of the esophagus on the Bernstein acid perfusion test, and this was also evidenced in another study performed by Dr. Goldenberg.

Dr. Goldenberg: In this case, a normal swallow with neutral barium showed no evidence of hiatal hernia, as in the previous case. There was no reflux from below the diaphragm to above the diaphragm, as was previously noted. Also, a smooth primary peristaltic wave was recorded.

With the administration of acid, there was a minimal disorganization of the primary wave, but much less so than on the preoperative study. Throughout this whole study, which probably contained 15 swallows, there is no evidence of reflux and no hernia.

Dr. Zuidema: Dr. Skinner, I assume you feel that the essential ingredient in the repair of the hiatal hernia and the elimination of the symptomatology is the creation of a valve-like mechanism at the cardioesophageal junction. Would you comment on the Mark IV operation and compare it with other techniques for reinstituting or reconstituting this valve?

Dr. Skinner: The upper end of the stomach and a segment of the lower esophagus below the diaphragm that remained empty throughout most of the swallowing phase were definitely visible. This esophagus was obviously compressed and the restoring of a segment of the esophagus to an intra-abdominal pressure environment which has an elevated pressure around the outside of the esophageal segment contributes to the compression and control of reflux. In addition, we bring the diaphragm around the lower esophageal segment and wrap a cuff of stomach around the anterior portion to complete the compression of the segment.

There are several types of hiatal hernia repairs that are frequently used to accomplish the same purpose. All share the same principles, however, in that they restore an intra-abdominal segment of esophagus and create some type of gastroesophageal flap valve mechanism.

The physician, in using the Belsey Mark IV repair, sutures a cuff of stomach to the anterior aspect of the esophagus and closes the diaphragm posteriorally to complete the ring of compression around the lower esophageal segment. It is held below the diaphragm like a cork in a bottle; the mass of reconstructed stomach and esophagus are held together below the narrowed hiatus.

The fundoplication of Nissen accomplishes almost exactly the same thing, and this is easier to perform from below the diaphragm through an abdominal incision. In the Nissen operation, the stomach is wrapped 360 degrees around the lower esophageal segment, which is again fixed on the underside of the diaphragm to prevent it from sliding back up into the chest.

The operation performed by Dr. Hill in Seattle accomplishes the same thing by lashing the gastroesophageal junction to the origins of the diaphragm at the aortic hiatus, thus reducing a long segment of intra-abdominal esophagus and allowing the fundus of the stomach to roll up onto the esophageal segment.

There are several other variations, but in this day and age, any operation performed to repair a hiatal hernia or reflux should incorporate these technical principles in the repair if good results in terms of protecting the patient from reflux and its complications are to be obtained.

Dr. Zuidema: I was quite impressed by Dr. Hill's results in 160 cases without a recurrence. Would you comment on the relative frequency of good results with the different procedures?

Dr. Skinner: It is hard to compare series done in different institutions and followed by different techniques. I think that in terms of recurrence rates, the Hill, Nissen, Husfeld, and Belsey type of repairs produce greater than 90% to 95% success. Dr. Hill's reported lack of recurrences is the best recurrence rate currently in the literature and his results are certainly good. I think the operation he proposes has very valid principles and is probably the easiest operation to perform from an abdominal approach to the hiatus.

Dr. Zuidema: Dr. Skinner, we also encounter the occasional patient who has symptoms of reflux without the presence of hiatal hernia. I think that this particular kind of patient may be a problem diagnostically as well as therapeutically.

Dr. Skinner: There are a number of patients that for years have complained of dyspepsia, indigestion, globus hystericus, or atypical coronary artery disease and have been diagnosed as such, who seem to have a normal upper GI tract because their X-rays are normal. We find that of those patients that we now have identified as being troubled with reflux problems, approximately 20% of them will not show a hiatal hernia by X-ray. So this led to the use of more sensitive tests for reflux, such as the one that we described in some detail with the pH electrode.

A patient who presents symptoms that suggest reflux, but who has a normal X-ray study, should not be dismissed as having a normal upper GI tract until some kind of reflux test is done, whether it be a cine barium study (more accurate than conventional X-ray) or a pH electrode reflux test (slightly more accurate than the cine studies). This kind of patient can be relieved of his reflux problems by the same kind of operation that we have discussed, since this operation is designed to prevent reflux, rather than just reduce the hernia.

Question from the Floor: Should pyloroplasty and vagotomy be done as part of hiatal hernia repair?

Dr. Skinner: Vagotomy and pyloroplasty or gastrectomy and vagotomy are championed by a number of people for reflux problems. I feel that if you perform an operation to prevent gastric contents

from reaching the esophagus, then there is no reason for concern about the amount of acid in the stomach, since it cannot reach the esophagus anyway. So we reserve vagotomy and pyloroplasty or vagotomy and gastrectomy for those patients who have *bona fide* indications for ulcer surgery. And, about 10% of patients with hiatal hernia will have coexistent ulcer disease. In such patients, I perform a vagotomy and gastric procedure. But we do not use it in the other patients.

We have collected a series of cases on patients who have developed symptoms of reflux and esophagitis *after* they have had a previous gastrectomy or pyloroplasty and vagotomy performed, so that reduction of acid alone without doing anything to the cardia is not good treatment for a hiatal hernia and reflux problems.

Question from the Floor: Dr. Skinner, what is the current position of doing the Allison repair or approximating the diaphragm? Is that still necessary?

Dr. Skinner: We certainly approximate the crura in all the types of repairs that we are discussing today. This provides the posterior buttress and prevents the reconstruction of the cardia from sliding up into the chest. The Allison repair is still one of the most common repairs done. However, we have had a chance to study several patients with the Allison repair, and there are several large series of patients reported in the literature who have had tests for reflux. The Allison repair has not been as effective in preventing reflux, even though it has succeeded in reducing the hernias. We feel that you must do something more than the Allison repair and closure of the hiatus. You should add some kind of reconstruction of the cardia to the procedure. The Allison repair has a recurrent rate of reflux of about 25% to 30%, whereas the hernia recurrences are much less frequent. Once again, you can have reflux without a hernia.

Case 3

Dr. Zuidema: The third case concerns a patient with peripheral vascular disease. The case will be presented by Dr. Brent Horsley.

Dr. Horsley: B.G. is an 81-year-old white woman who presented herself to The Johns Hopkins Hospital for the first time on the service of Dr. Robert Rutherford complaining of a "blister on the artery in her stomach". The family history was significant, in that her 56-year-old son had been recently evaluated and treated at our hospital for claudication and probable angina pectoris.

The patient herself was in very good health for her age. She had had two major operations in the recent past—a vaginal hysterectomy with anterior and posterior repair in 1956, and a cholecystectomy in 1962.

The review of systems was significant in revealing the following cardiac symptoms: occasional palpitations, one-and-a-half flight dyspnea on exertion, and three times nocturia but no angina, orthopnea, or pedal edema. She had had hypertension which had been treated for the past three years with 50 mg of a combination of two antihypertensive agents (*Hydropres*) per day.

Radiographic examination of her gastrointestinal system showed a hiatal hernia, with mild symptoms for which she had been treated with phenobarbital and banthine. An earlier barium enema revealed diverticulosis of the colon. Finally, she had had some syncopal episodes without localizing signs.

The patient dated the onset of her present illness approximately one year prior to her admission to The Johns Hopkins Hospital, when she had begun to notice some pain in her left lumbar area or flank. She experienced this pain most frequently two to three hours after eating. There was no associated anorexia, weight loss, or changes in bowel function.

She presented herself to her local physician with this complaint of pain. During his evaluation, a questionable pulsatile mass in the left upper quadrant was felt. Because of the consideration of an abdominal aortic aneurysm, the patient was referred to Dr. Rutherford for definitive evaluation and consideration of surgery.

Physical examination revealed an elderly lady who was mentally alert and physically active. Her vital signs were normal, with the exception of a blood pressure of 170/90. The heart and lungs were within the normal limits for this age. There was a soft systolic ejection murmur in the aortic area. Abdominal examination revealed a pulsatile, slightly tender mass in the left upper quadrant which was hard to outline because of her obesity. She had no organomegaly, and except for the scar of her previous cholecystectomy, the remainder of the abdominal examination was negative.

Her peripheral vascular examination was essentially normal. Pulses in both the upper and lower extremities and the neck were full and equal.

Laboratory studies revealed routine hematologic and chemistry studies to be within normal limits. The electrocardiogram showed a left bundle branch block and the suggestion of an old anterior myocardial infarction, but no acute ST or T wave changes. Radiographic studies revealed a calcified saccular aneurysm about 7 cm in diameter in the lower aorta between the level of the renal arteries and the aortic bifurcation.

The patient was taken to the operating room. The abdomen was opened through a long midline incision revealing the aneurysm. The aneurysm was resected, and the posteromedial wall was left attached to the inferior vena cava. The specimen was saccular in form and partly filled with laminated clot. Aortic continuity was restored by bridging the

defect from about 7 cm below the renal arteries to the aortic bifurcation with a dacron prosthesis sutured in place with running OO Teodek. The patient's postoperative course was uneventful.

Dr. Goldenberg (in discussing the patient's X-rays): A frontal view of the abdomen shows the renal shadow, and there is another soft tissue shadow and a soft tissue mass with some calcification which looks like the aorta. There is another small calcification about the periphery of the soft tissue mass. A lateral view of the mass shows the outline of the aorta as it merges with poorly defined soft tissue mass.

From an upper GI series, calcification can be seen. Below this is a soft tissue mass with peripheral calcification representing a saccular aneurysm protruding anteriorly from the aorta. As previously mentioned, the diameter of this aneurysm was approximately 7½ cm.

A high translumbar aortogram showed the aneurysm beginning well below the take-off of the renal arteries. Another showed the aneurysm ending with good runoff at the aortic bifurcation. Once again, the lateral view of the same study compared the apparent diameter of the aneurysm on plain film with that demonstrated by the aortogram. The discrepancy in diameter probably represents a clot in the anterior portion of the saccular aneurysm.

Discussion

Dr. Rutherford: This particular patient was chosen because she illustrates a number of points which reflect current concepts in the management of primary abdominal aortic aneurysms.

First, the patient's diagnosis was suspected on physical examination and was confirmed by plain films of the abdomen, including a cross-table lateral. How often can one make the diagnosis on these studies alone? We do not have much exact information on this, although it is quite frequent. There is one study by Robb that reports that 89% of the cases of abdominal aortic aneurysms had a calcific outline or a soft tissue tumor or mass on the plain films of the abdomen. Some physicians have even been willing to rule out the diagnosis of aneurysm if these films are negative. However, in our experience at Hopkins, we do not feel that these plain films of the abdomen, including the cross-table lateral, are as commonly diagnostic, particularly in the younger patients. We have seen three young patients this year who have not had a calcific outline. We are presently exploring the use of tomography to increase this yield.

On the other hand, if there is a calcific aortic outline and there is no widening, you can safely exclude the diagnosis of aortic aneurysm.

Next, one might question the need for translumbar aortography here, since the diagnosis was established on plain films, and instead be concerned about its risks, particularly in the presence of an aneurysm. We now do translumbar aortography quite a bit higher up and insert a teflon catheter through the needle, which is a much safer technique.

In this particular patient, aortography was done because of her age and obesity. If we had found either a small fusiform aneurysm or a large aneurysm that extended above the renal arteries, we would have been dissuaded from surgery.

The indications for surgical resection of abdominal aortic aneurysms were not very controversial a decade or so ago, because there had been several reports which indicated that two thirds of all patients with this diagnosis would be dead within two or three years following surgery. For this reason, aneurysmectomy was usually routinely performed. However, more recent reports have challenged this tendency to resect all abdominal aortic aneurysms. These reports have pointed out the fact that not all patients in these nonoperated series who died during this brief follow-up period died of aneurysmal rupture. In fact, a considerable portion of these patients died because of arteriosclerotic complications in other locations, complications such as myocardial infarction or stroke. These reports also point out that these same complications occurred in patients surviving aneurectomy. Finally, there have been a number of reports suggesting that the smaller aneurysms do not rupture quite so readily. The incidence of rupture in the larger aneurysms is about four times as frequent as in the smaller ones.

Probably the best statistics on the subject have been offered by Szlagyi, who presented cumulative survival rates comparing operative and nonoperative cases that had been standardized for age, cardiac status, and blood pressure. Unfortunately, he did not incorporate the operative mortality in his original statistics.

There is quite an advantage of surgical over nonsurgical measures in treating larger aneurysms (those over 6 cm in diameter) because of the high rate of rupture which occurs in the first two or three years. The advantages of surgery in treating the smaller aneurysms, though definite, are much slimmer. Since the slopes of the late survival curves are not too dissimilar in all of these groups, what one must do in selecting surgical candidates is to weigh the immediate risk of operation against the risk of rupture which usually occurs within the first two or three years.

Overall statistics from the major reported series have shown that about one third (or slightly more) of the patients treated for aneurysms will die of rupture, about one third will die of other conditions (mainly myocardial infarction or stroke), and about one third (or slightly less) will survive for five years if not operated on. Balanced against this we must place an immediate operative mortality rate which now probably approaches 5% in major in-

stitutions, plus an additional late mortality rate of approximately 10% from graft failures and related complications.

Against this general background, we must consider the patient's age, operative risk, size of the aneurysm, and symptoms. For example, associated abdominal pain or tenderness carry a very poor prognosis without surgery. Approximately 70% of the patients who rupture their aneurysms do so within a week of the onset of pain, 80% within a month, and 90% within a year.

Age was obviously a consideration in treating this patient, and we gave it much thought before deciding to operate. When does one withhold aneurysmectomy on the basis of age alone? Some surgeons would exclude all cases over the age of 70. Edmonds has presented some comparative statistics on the operative vs the nonoperative management of octogenarians with abdominal aortic aneurysms. These statistics show that in spite of the higher initial mortality in operative cases (which apply mainly to the cases with cardiac symptoms), this is more than offset by the time of the three and five year followup, at which time the overall mortality rates for operative cases are about half those of the nonoperative cases, regardless of cardiac status. However, there is probably some selection built into these statistics, since they were taken from different series.

In the final analysis, one has to individualize for a given patient. In this particular patient, we decided to operate in spite of her age and obesity, because she still led a very active life, had no significant evidence of arteriosclerotic problems elsewhere, and had an aneurysm which we would classify as large. The jet of the aorta flow was directed not straight into the distal aorta and arteries, but into the sac of the aneurysm at an area in the wall where there was no laminated clot, so that the wall was quite thin. Finally, this patient did have abdominal tenderness in the area of the aneurysm on examination. We were never sure that her pain was caused by the aneurysm, but we could not ignore the tenderness.

It must be remembered that if one elects to withhold aneurysmectomy, one must be willing to accept an operative mortality rate of 33% to 67% for emergency operation, which does not include the cases that do not reach the operating room. The operative mortality for elective aneurysmectomy has gradually dropped over the years from about 15% to around 5%, due to refinements in operative technique, anesthesia, and supportive care. Even in the immediate postoperative mortality, as in the late mortality, half of the patients die of complications related to their generalized arteriosclerosis, particularly myocardial infarction. And these other complications, such as cardiovascular accidents, intraoperative hemorrhage, shock, and renal failure can be minimized. For example, avoiding dissection of the aneurysm from the inferior vena cava reduces the interoperative blood loss and the aortic occlusion time.

The next group of complications include the technical failures and recurrent primary aneurysms above the proximal suture line, disruption of the suture line with hemorrhage, and false aneurysm or aortoenteric fistulas. These have been reduced by the inclusion of an additional proximal segment of diseased aorta in the resection, improved prosthetic and suture material, and careful reperitonealization to isolate the duodenum from the upper suture line.

Finally, regarding the final complication, ischemic colitis, if the inferior mesenteric artery (which is frequently, but not always, occluded in aneurysms) is patent or suspiciously large, or if the superior mesenteric or iliac arteries are noted to be occluded or there is a bruit over them, then one should consider preserving the inferior mesenteric artery. The usual procedure is to clamp the inferior mesenteric artery with a vascular clamp and remove it from the aneurysm with a small cuff. Then, after performing the anastomoses, the viability of the bowel is noted and felt for pulsations. A clamp is released to check for good backbleeding. If these signs are present, there is no need to worry about ligating the vessel. Otherwise, it is preferable to anastomose it to the side of the graft.

Finally, I think that pulmonary complications, particularly in older people, are significant. In this particular patient, we did not take any unnecessary chances. We kept her on the respirator overnight and kept suctioning out her tracheobronchial tree. This seemed to play a significant role in her recovery.

Case 4

Dr. Zuidema: The final presentation involves a patient with cirrhosis, portal hypertension, and bleeding esophageal varices. The case will be presented by Dr. Richard Scott.

Dr. Scott: This was the first Hopkins admission of a 46-year-old white male attorney who was transferred to Hopkins from eastern Maryland for evaluation of upper GI bleeding. The past medical history and review of systems are noncontributory. The social history was significant only in that the patient had a 20-year history of heavy alcohol intake.

The patient traced the onset of his present illness to 1964 when he was hospitalized in eastern Maryland with infectious hepatitis. Some time later, the patient experienced an episode of generalized malaise, hematemesis and melena on three consecutive days. On the third day, the patient was again hospitalized in eastern Maryland.

Physical examination upon this hospitalization showed a generally well-developed, well-nourished man with a severely protuberant abdomen, with

four-plus ascites and massive hepatomegaly with four-plus guaiac stools. At this time, the patient had a hematocrit of 34% which subsequently dropped to 21%. The patient received four units of whole blood which raised his hematocrit to 34%; it remained stable at this level. An upper GI series revealed the presence of numerous large esophageal varices. A decision was made to transfer the patient to Hopkins for further evaluation.

Physical examination upon admission to Hopkins showed the patient to be in no apparent acute distress. He was afebrile with normal vital signs. The heart and lungs were unremarkable. Examination of the abdomen revealed it to be slightly protuberant, soft, with normal active bowel sounds, and a liver edge palpable approximately seven finger breadths below the right costal margin. The remainder of the examination was well within normal limits.

The pertinent laboratory data revealed a hematocrit of 34% and a prothrombin time of less than 25%. A diagnosis of Laennec's cirrhosis, with portal hypertension and esophageal varices, was confirmed. The patient underwent esophagoscopy, at which time numerous large esophageal varices were demonstrated without any active site of bleeding. On January 10, 1969, the patient underwent exploratory surgery by way of a large right subcostal incision to permit an end-to-side porta-caval anastomosis. The pre-anastomosis portal vein pressure was recorded as 43 cm of water, and the postoperative portal vein pressure was recorded after the end-to-side anastomosis as 29 cm of water. The patient tolerated this procedure very well, and was returned to the recovery room in satisfactory condition. His postoperative course was uneventful, and he was discharged in satisfactory condition on his 14th postoperative day.

Dr. Goldenberg (discussing the radiological findings): The preoperative chest of the patient showed bilaterally elevated diaphragms. The one on the right was the most markedly elevated, probably a result of the enlarged liver. An upper GI series showed serpentine radiolucencies in the lower esophagus, which are probably large esophageal varices.

Dr. Bieseker (discussing the pathological findings): An open biopsy of the liver taken during the operation showed cleared areas of fatty infiltration interspersed among areas of liver tissue. There was an abnormal amount of fibrous tissue. Around these lobules of liver of different sizes there was a sprinkling of inflammatory cells found in the portal areas.

A Masson's stain showing the extensive amount of fibrosis also revealed lobules of liver of different sizes, some large, some quite small. These sometimes appeared to be bisected with fibrous tissue distributed actually within the lobules themselves. This amount of fibrosis in the presence of the fat that is distributed throughout the lobules, both large and small, is very suggestive of a diagnosis of Laennec's cirrhosis. (We use the term cirrhosis when there is evidence of liver injury with regeneration and fibrosis present.) There were many mononuclear cells (lymphocytes) spread throughout the portal areas. There was also a suggestion of bile duct proliferation. The liver cells suggest injury, in that the cytoplasm had become vacuolated. In certain areas, there was a pinkish discoloration of the cytoplasm suggesting cell damage. Occasionally, there was a cell that may be polymorphonuclear. Some of these liver cells appeared to be degenerating in areas.

The pinkish discoloration of the cytoplasm can be interpreted as alcoholic hyaline. With this liver cell injury, there was also a sprinkling of inflammatory cells throughout some of the parenchyma.

In summary, the liver had a well-established cirrhosis with scarring and alcoholic hyaline. There was a minimal-to-slight chronic active hepatitis present.

Dr. Zuidema: This case illustrates a number of features of patients with portal hypertension and some typical considerations in terms of their management.

This particular patient illustrates the method of choice in managing patients with this problem. The patient gave a typical history, was admitted to the hospital, and responded very promptly to supportive therapy. This gave us and his physicians in eastern Maryland an opportunity to properly prepare him for portal decompression.

On admission the patient was noted to have marked ascites. This was treated medically during the course of his hospitalization, both in eastern Maryland and at The Johns Hopkins Hospital, and he responded very well. At the time of the operation he had very little ascitic fluid, perhaps 50 to 60 cc, and had therefore very favorably responded to treatment. This is the case in virtually 98% or 99% of the patients with portal hypertension and ascites. Although a considerable amount of attention has been given to the use of portal decompression for the treatment of ascites, in most cases this is unnecessary. By careful salt and fluid restriction, and by the judicious use of diuretics, the ascites will be controlled. We usually begin with hydrodiuril and change to ethacrynic acid if necessary. Aldosterone antagonists can also be used to advantage if the ascites is slow to clear. This is perfectly satisfactory. We know that a side-to-side type of shunt can very satisfactorily deal with patients with refractory ascites. But there are relatively few instances in which it has to be employed.

One might question the necessity of performing esophagoscopy, when the X-ray diagnosed esophageal varices. However, the patient was being prepared for an elective porta caval anastomosis, and we wanted to be completely accurate in our preoperative evaluation. Dr. Eddy Palmer and others have

shown the frequency with which other sources of GI bleeding may be found in patients with cirrhosis. Dr. Palmer has estimated that as high as 20% to 25% of patients presenting with upper GI hemorrhage and cirrhosis of the liver may have other GI sources at fault. Most commonly, these include patients with peptic ulcer disease who ordinarily have a higher incidence of peptic ulceration.

The other significant contributing agent is the group of patients with alcoholic gastritis who are admitted with acute hemorrhages. We want to be as precise as possible in our diagnosis, for in some instances, a porta caval anastomosis is not necessary for control of their portal hypertension. In fact, it is a very poor operation for gastritis. There will also be some patients with the Mallory-Weiss syndrome, the mucosal lacerations at the esophagealgastric junction. And these too should be diagnosed preoperatively, if at all possible.

At any rate, we were convinced, on the basis of the radiological and esophagoscopic findings, that the patient had been bleeding from his esophagogastric varices. There was no sign of gastritis or peptic ulceration, and consequently, the portal decompression was performed.

There is some current debate concerning the best method of managing patients with portal hypertension. With each episode of hemorrhage in a patient with cirrhosis, approximately 17% of the patients will die with the first hemorrhage. About the same number will die with the second hemorrhage, and this will then rise with the third episode until, by the fourth and fifth episodes, approximately 50% of the patients will die from upper gastrointestinal hemorrhage alone. This is in marked contrast to the patients developing portal hypertension on the basis of portal vein thrombosis. The latter group have portal hypertension, but have well-preserved hepatic function. And, the mortality associated with each individual episode of hemorrhage is substantially lower. Consequently, there is a significant difference in the life expectancy in these two groups and in the method of management.

After the first episode of bleeding, 70% of the patients with cirrhosis will be dead at the end of about one year. In reviewing studies by the Boston Interhospital Liver Group, and Ratinoff and Patek in 1942, few changes have been made in the past 25 years in the treatment of patients with cirrhosis.

Studies by Merendino and Volwiler again show that the life expectancy falls after the first hemorrhage, and in contrast, falls after the discovery of varices, but before hemorrhage has occurred. (Actually, only about 30% of patients with esophageal varices bleed from them, and therefore become candidates for operation.) The mortality shown in patients who do not bleed can be attributed directly to the deterioration of their liver function. The mortality in patients who do bleed is due to the deteriorating liver function and the additional stresses of hemorrhage, repeated transfusions, aspiration pneumonia, etc. To determine the state of the liver function or operability, the patients can be clinically divided into categories according to their liver function as to A, B, or C on the basis of serum bilirubin, the ability of the liver to synthesize albumin, the presence or absence of ascites (and if so, whether it is easily controlled), whether or not the patient has ever had an episode of portal-systemic encephalopathy, and finally, whether or not he is able to maintain a reasonable state of protein nutrition. This shows up most graphically in the loss of lean muscle mass, the wasting away of the skeletal muscle. Our patient fell into the B category. In addition, his prothrombin was low and remained low despite the administration of an aqueous colloidal solution of vitamin K1 (AquaMEPHYTON).

Whenever one encounters a patient with portal hypertension and considers him a candidate for portal decompression, one must be concerned with the risk of portal systemic encepholopathy following portal caval anastomosis, which is the major complication in the postoperative period.

A clinical study by Wantz and Payne again divided the patients into groups A, B, and C. There was only an 8% incidence of portal systemic encephalopathy in the good risk group postoperatively. Two thirds of these cases were transient and temporary in nature.

In the B group, the incidence rose somewhat, but it is not until you get to the poor risk group, the C patient with cirrhosis, that you begin to develop a very high incidence of crippling encephalopathy.

Our own experience with hepatic encephalopathy developed after end-to-side porta caval anastomosis shows that in the good risk group, there was no appreciable incidence of encephalopathy. The moderate risk group had an incidence of 20%, but it was the transient, nonrecurrent variety. So it was our feeling that this patient faced only a very modest risk of developing this complication, and indeed he failed to develop it in the postoperative period and in his follow-up period to date.

Obviously, portal decompression has something to offer to patients in terms of controlling recurrent variceal hemorrhage. There have been enough studies now to realize that the determinant factor affecting the patient's longevity is the basic hepatic function which he enjoys. It is essential that these patients totally and completely give up alcohol. If not, they commit very slow suicide. It is not at all unusual for a patient who continues to use alcohol to develop late hepatic failure.

On the other hand, there are a great many patients, particularly with portal cirrhosis, who on the basis of long-term follow-up, have done extremely well up to ten and eleven years without developing any later manifestations or complications.

Jesse C. Coggins Fund Lecture

Presented at the 1969 Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, April 9.

Intrasynovial Corticosteroid Therapy in Arthritis

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I am not a geriatrist, in that I do not limit my practice of medicine to those in their declining years. Actually, however, as a rheumatologist or "arthritis specialist", I have found myself intimately concerned with many painful afflictions that seem to be an inescapable part of what can euphemistically be called our "period of receding youth". The majority of my patients are over 50 years of age.

In trying to fulfill the physician's time-honored ambition "to cure a few, to help many, and to comfort all" his patients, we are too often frustrated. It has been a great personal satisfaction to have devised a method for local palliative treatment which has become more and more successfully used by physicians over the past 18 years, and now is accepted as a standard form of local therapy for arthritis and related conditions. Intrasynovial corticosteroid therapy, which we introduced in 1951, appears to have withstood the test of time.[1] We have injected suspensions of steroid into inflamed joints, bursae, or tendon sheaths of more than 8,000 patients a total of nearly 250,000 times during this period of years. Such injections have been repeated, as needed, for continuing suppression of *non-septic* local inflammation over periods of many years without the hazards incident to systemic corticosteroid therapy. Whenever the local inflammation is a part of a systemic disease, such as gout, rheumatoid arthritis, or systemic lupus erythematosus, local steroid treatment is only an adjunct to general therapy of patient and disease.

The danger of adverse reactions from intrasynovial steroid injections is small, *providing* careful technique is employed. Fastidious aseptic precautions for injections and proper placement of the anti-inflammatory medication within the inflamed joint, tendon sheath, or bursa are both extremely necessary to avoid introducing infection and to assure the effectiveness of each injection.

Aspiration of joint fluid is extremely helpful in differential diagnosis of arthritis, and a diagnosis should be made before steroid is injected, at least to exclude infection as the cause. Aspiration and injection of joints in arthritis, therefore, can be of both diagnostic and treatment value at the same time. In our clinic we jokingly refer to this as "instant diagnosis and treatment".

Synovial Fluid Analysis (Synovianalysis)

In earlier reports,[2, 3] we have reviewed simple methods for performing a routine analysis of synovial fluid. We have emphasized that the appearance of the fluid is often helpful since the fluid from osteoarthritis is clear and yellow, that from rheumatoid arthritis is cloudy with a greenish tint, that from traumatic arthritis is usually blood-tinged, and that from gout may look similar to that of rheumatoid arthritis or may be almost milky white. The viscosity of the fluid may readily be estimated simply by dropping the fluid from a syringe or dropper, or by stringing it from a drop between two fingers. Dropping fluid into acetic in a beaker will form a clot. If this clot is firm and does not break up on shaking, the mucin clot is normal, as in osteoarthritis. If the clot is friable and breaks into shreds or even makes the surrounding fluid cloudy on shaking, the poor quality is more typical of an inflammatory arthritis such as rheumatoid arthritis, gout, or septic arthritis.

Cell counts of the synovial fluid are performed as for a white blood cell count, but using 0.3% saline as diluent is preferred for accuracy. Very cloudy fluids are also sent for cultures for microorganisms. Differential cell counts on the fluid may be done by centrifuging the fluid and smearing the sediment out on slides for staining with Wright's stain.

The above is a quick review of some of the simple tests. Most important of all is to place a drop of fresh synovial fluid on a microscope slide, cover with a cover slip, and examine it under the microscope.

In the fluid from an osteoarthritic joint the number of cells is small, and most are lymphocytes or synovial lining cells. Also present, however, are fragments or chards of cartilage broken off from the surfaces. The fragments are suspended in the fluid for long periods, but are finally digested by phagocytes.

In 1960 we first demonstrated[4] that in fluid from gouty joints, crystals of sodium biurate are seen as small rod-like or needle-like fragments, appearing dark under ordinary light, bright under polarized light, and in yellow or blue against the red background if a red plate compensator is used in a polarizing microscope. In the fluid from an acute gouty joint these crystals are nearly all intracellular, undergoing phagocytosis by the neutrophiles. This finding has helped to establish that the acute gouty attack is brought about by the rapid deposition of urate crystals in a joint, causing sudden chemotaxis of neutrophiles to phagocytize these foreign bodies. Gouty attacks can be produced in normal volunteers and in gouty patients simply by injecting enough urate crystals into a joint. Thus you can see that these findings on synovianalysis opened a long neglected field of research in gout, and led to some important new data on the pathogenesis of gout.

In looking at fluids from patients with severe osteoarthritis, and others with non-gouty acute attacks of joint swelling, McCarty[5] found crystals that were not urate, but somewhat resembled it. He was able to demonstrate by chemical and X-ray diffraction that such crystals were calcium pyrophosphate, and such crystals were characteristic of what he called pseudogout, described by others from X-ray appearance as chondrocalcinosis. Such crystals may be seen throughout the bits of cartilage found in joint fluid from such patients, may float free, or may be intracellular. It has been shown *by synovianalysis,* therefore, that a new entity, chondrocalcinosis, consists of a deposition of calcium pyrophosphate crystals in joint cartilage *and joint fluid.*

In 1963 Dr. McCarty's laboratory and ours observed a new finding in the fluid of rheumatoid arthritis. It has always been puzzling to us why the fluid of rheumatoid arthritis contains so many neutrophilic leukocytes, whereas the synovium itself is loaded with lymphocytes and plasma cells. In many of the leukocytes seen in rheumatoid arthritic synovial fluid there appear relatively large and dark granules in the cytoplasm of the unstained cells. These granule-bearing leukocytes have not been morphologically specific for rheumatoid arthritis, but have opened the way for a whole new line of research on the pathogenetic mechanism of rheumatoid joint inflammation.[6] Again, this illustrates what careful study of synovial fluid can bring to light.

In the synovial fluid from inflamed joints of patients with systemic lupus erythematosus, as well as in pleural or pericardial fluid, the sediment can be smeared on a slide, stained with Wright's stain, and many typical L.E. cells will be seen. In the fluid from joints of a patient with Reiter's syndrome, as well as in some other acute inflammatory forms of arthritis, peculiar giant cells containing phagocytized leukocytes may be seen.

In joint fluid or bursal fluid from long-standing rheumatoid arthritis we often see cholesterol crystals. This is "cholesterol gout", but most of the facts about this are still unknown. Joint fluid may also contain crystals of corticosteroid if such has been recently injected. In short, much can be learned from examining synovial fluid, and there is still more to be learned.

General Technique for Joint Aspiration and Injection

Before any joint is aspirated, the physician is wise to refresh himself on the local anatomy from an ana-

tomical atlas and X-ray photographs of the inflamed joint. The object of joint paracentesis is to puncture the involved synovial space as painlessly as possible, aspirate any synovial fluid, and then inject the steroid with minimal trauma and without introducing infection. The optimal site for paracentesis of a joint is usually on the extensor surface at a point where the synovium is closest to the skin, and at a point comfortably remote from any major artery, vein, or nerve. Details for injection of specific joints, tendon sheaths, and bursae have been described in Chapter 24 of our textbook *Arthritis.*[7]

When the site for paracentesis of the joint, tendon sheath, or bursa has been determined, the overlying skin is scrubbed with antiseptic detergent, then painted with antiseptic solution and allowed to dry. If marked effusion is present, it is seldom necessary to procainize the tissues, as the needle can be inserted quickly and almost painlessly. A brief spraying of the injection site with ethyl chloride makes needle insertion through the skin painless. If procaine infiltration is felt necessary, a small skin wheal is made with infiltration down to the synovium injecting about 2 cc-4 cc of procaine.

The aspirating needle, #19 or #20 gauge, is inserted through skin, subcutaneous tissue, capsule, and synovium quickly but gently, with a "sliding" rather than a strong thrusting motion. Disposable needles, used but once, are consistently sharp and meet little resistance. The aspirating syringe plunger is gently withdrawn to pull out any fluid in the sac for synovial fluid analysis. Sometimes fibrin within the space, or folds of synovial tissue, will plug the needle by acting as a flap-valve. Gentle reinjection of a little of the fluid may displace this, permitting withdrawal of all the fluid. From a larger synovial space, such as the knee, not fully distended by fluid, more can be withdrawn by "milking" the synovium with the hand toward the site of aspiration. After all available fluid has been withdrawn, the aspirating syringe is detached, leaving the needle in place. (If fluid is turbid or purulent, culture is taken and no steroid injected until diagnosis is established.)

The desired amount of corticosteroid suspension is drawn into the smaller syringe (usually about ½ cc-1½ cc depending on joint or bursal size), and then the syringe is attached to the aspirating needle, still in place, and the suspension gently injected. If more than gentle pressure is required on the plunger of the syringe, the needle should be readjusted as it is probably not in the synovial space. After injection of the steroid, the syringe and aspirating needle are withdrawn, the skin cleansed with alcohol sponges, dried with gauze pads, and a small patch dressing is applied. The patient may then resume necessary activity, but should be warned not to abuse the recently injected joint.

Joint injections may be repeated indefinitely, but only as needed for recurrence of joint pain and swelling. Reinjection is not advisable more often than once monthly into a given joint, and longer intervals are desirable whenever possible. We have reinjected an arthritic joint more than a hundred times over the past 17 years, but recommend both minimal steroid dosage and infrequent reinjection in most cases, as this decreases the chance for development of instability in the affected joint.

Choice of Steroid for Intra-articular Injection

Hydrocortisone acetate suspension was the first preparation used for intrasynovial injection. Although this induced palliation of the inflammation in most joints, the duration of effect was sometimes less than a week. After a search for longer-lasting local corticosteroid, we found that a branched-chain ester enhanced the duration of the repository steroid in the joint, apparently being more slowly dissociated by the enzymes. On the average, injection of hydrocortisone t-butyl acetate was followed by twice as long a period of relief from pain and swelling as the hydrocortisone acetate in equal dose had produced previously (Table 1).

Table 1: Comparative Duration of Palliation in 20 Rheumatoid Arthritic Knee Joints

Hydrocortisone Acetate (37.5 mg)	**6.0 days**	**(average)**
Hydrocortisone t-Butyl Acetate (37.5 mg)	**12.1 days**	**"**
Prednisolone Acetate (30 mg)	**7.8 days**	**"**
Prednisolone t-Butyl Acetate (30 mg)	**14.5 days**	**"**
6-Methyl Prednisolone Acetate (30 mg)	**8.2 days**	**"**
Dexamethasone Acetate (5 mg)	**7.6 days**	**"**
Dexamethasone t-Butyl Acetate (5 mg)	**14.9 days**	**"**
Triamcinolone Diacetate (30 mg)	**7.7 days**	**"**
Triamcinolone Acetonide (30 mg)	**14.2 days**	**"**
Triamcinolone Hexacetonide (20 mg)	**21.2 days**	**"**
Betamethasone Acetate (5 mg)	**8.7 days**	**"**

Other steroids, and a variety of esters of these steroids were studied by repeated injection into joints. The average duration of effectiveness from each is listed in the table. It will be seen that prednisolone t-butyl acetate has palliated as long after injection as any of the newer steroids except one. That one has just been cleared for general intra-articular use by the FDA after we had studied it for nearly ten years. Triamcinolone hexacetonide, now marketed as *Aristospan,* will usually give longer and more complete relief after injection into a joint than any other available preparation. It is the one we use whenever prednisolone t-ba does not suppress local inflammation for a long enough period to be of practical value. Because of its potency, however, *Aristospan* is also the easiest to abuse, so we limit the dose to 20 mg into any large joint, and repeat injections no oftener than every six weeks.

There are some patients in whose joints it seems to make no difference which of the steroid suspensions are used, as all are equally effective for about the same length of time. The value of having available alternative steroid suspensions is for treating those who achieve transient relief from one preparation, even on repeated trials. Such patients often experience relief in the injected joint for weeks or months from another steroid.

Long-term Results from Repeated Intra-articular Steroid Therapy

Injection of corticosteroid into an arthritic joint never cures the condition. Only when there is *temporary* involvement of a certain joint does such treatment seem to have a "permanent" palliative effect. Since bursitis is usually a transitory inflammation, steroid injection may be said to "cure" it, as complete relief is usually prompt and may last indefinitely.

Follow-up on more than 8,000 patients has been impossible, but we have chosen to follow the first 100 patients who received steroid into rheumatoid arthritic knees over the past 17 years, and the first 100 patients with osteoarthritic knees treated similarly. The results are tabulated in Table 2. Of those requiring relief from rheumatoid arthritic knees, nearly 40% no longer need repeat injections as their knees have ceased to be actively inflamed during the follow-up years. Thirty-three knees were still active enough to require occasional reinjection. Of these 70 knees, however, the most significant finding was the *absence* of flexion contractures, and the continued good function of the knees even after 17 years, whether or not the X-rays showed increased erosions and narrowing of the joint spaces. The same was true for nearly 80% of the osteoarthritic knees. Of the others, a sizable percent required arthroplasty (11% of rheumatoids and 5% of osteoarthritics), and in some the injections were abandoned because relief was too transient to justify continuation. The injections did not cure the arthritis in any; probably did not retard the disease in many; may have accelerated the destruction in some; but *did* seem to prevent deformities in most of the rheumatoids and helped most of both groups to continue walking in greater comfort for as long as 17 years.

Similar results have been noted following repeated injection of other joints with corticosteroid for rheumatoid and osteoarthritis, with an even smaller incidence of increasing difficulty in non-weight-bearing joints, and in bursae or tendon sheaths. This cannot be said, however, for hip joints, even in osteoarthritis. The last portion of Table 2 shows that well over half have required and had arthroplasties, either cup or Austin-Moore prostheses, because of continued or even accelerated deterioration of the joint. Less than 10% no longer require injections because the arthritic pain ceased to be a problem, and in 21% occasional injections are needed. If one or a few injections into a hip do not give lasting relief from pain when physical activity has also been limited to necessary weight-bearing only, operation is usually indicated.

Table 2: First 100 Rheumatoid Arthritic Knees, after 17 Years

Injections Discontinued, no longer needed	**37**
Still Receiving Periodic Injections	**33**
Injections Stopped—Synovectomy, Arthroplasty	**11**
Injections Stopped—Ineffective	**6**
Patient Died from Systemic Disease	**4**
Infection of Knee, requiring Arthrodesis	**1**
Could not be Traced for Follow-up	**8**
X-rays showed progression of disease in 61, of 82 checked	

First 100 Osteoarthritic Knees, after 17 Years

Injections Discontinued, no longer needed	**57**
Injections Discontinued, arthroplasty done	**5**
Still Receiving Occasional Reinjections	**22**
Injections Discontinued—inadequate relief	**11**
Could not be Traced for Follow-up	**5**
X-rays showed progression in 37, of 67 checked	

First 100 Osteoarthritic Hips, after 17 Years

Injections Discontinued, Arthroplasty done	**57**
Injections Occasionally Repeated as needed	**21**
Injections Discontinued, no longer needed	**9**
Patient Died from Unrelated Disease	**6**
Could not be Traced for Follow-up	**7**
X-rays showed progression in all 93 checked	

Adverse Effects from Intra-articular Steroids

The most common undesirable effect from corticosteroid injection into an arthritic joint has been a temporary exacerbation of the inflammation, paradoxically from the steroid itself. McCarty and Hogan[8] have demonstrated this "post-injection flare" is a crystal-induced synovitis. It occurs after less than 2% of injections, and usually lasts only a few hours, after which the anti-inflammatory effect of the steroid predominates over the irritating effect of the injected microcrystals.

Infection has occurred in a joint following steroid injection a total of 18 times in our series (Table 3). This incidence is less than one per 10,000 injections, or 0.076%. During the past eight years, the incidence of infection following injection has been less than 1 per 15,000 since we have used disposable syringes and needles exclusively, in addition to our customary careful skin cleansing and use of antiseptic solution. The occurrence of joint infection is a serious complication, and must be carefully and continually guarded against.

Whenever the joint that has been injected becomes inflamed for more than a few hours, aspiration for re-examination and culture are strongly recommended. Prompt diagnosis and treatment of such infections results in little morbidity. This result was achieved in 11 of our 18 iatrogenic infections in whom diagnosis

was suspected and adequate treatment instituted within 48 hours. In the other seven patients, diagnosis or institution of adequate antibiotic therapy was delayed for at least several days, resulting in a prolonged course of weeks or months, surgical drainage, and eventual loss of considerable joint function in four cases, and the need for arthrodesis in the other three. Such cases are rare, but disastrous. All these latter seven infections were staphylococcic, but were sensitive to some of the available antibiotics.

Table 3: Summary of Adverse Effects after 18 Years (Approximately 235,000 injections in about 8,000 patients)

Post-injection Flareup of Symptoms (Crystal Induced)	**2% of Injections**
Infection of Joint after Injection (18 instances)	**0.076% of Injections**
A. Prompt Diagnosis and Adequate Therapy—Good Result	**11 patients**
B. Delayed Diagnosis, and/or Inadequate Therapy—Surgical Drainage, Long Course, or Arthrodesis	**7 patients**
Instability of Injected Joint—Osteonecrosis of Knee or Hip (79 joints of 62 patients)	**less than 1% of patients**

The most serious complication of repeated corticosteroid injections into arthritic joints has been the development of instability of that joint, apparently from development of osteonecrosis of the juxta-articular bone. Although this occurred in less than 1% of our more than 8,000 patients, many more could have developed if we had not become alerted to this danger fairly early in our experience.

Whether osteonecrosis is caused by the steroid injection itself, or by abuse of the joint permitted by removal of the warning sign of pain, is not definitely known. We have noted this has only occurred in weight-bearing joints (hip and knee), particularly if larger doses of steroids have been used, or if injections have been repeated more often than once monthly for a long time. This problem has been the reason we warn that minimal doses of steroid should be used, and repeated injections made at infrequent intervals.

In all of the 37 hip joints which developed aseptic necrosis while under intra-articular steroid therapy, an Austin-Moore prosthesis was required for maintenance of function, and knee prosthetic arthroplasties were required in 42 instances because of increasing lateral instability of the treated knee. Again, the rarity of this complication in this large series must not minimize the danger, and its occurrence makes us aware that we are not curing the arthritis, only palliating the symptoms. The disease goes on its destructive way, and may actually be accelerated by "sweeping the symptoms under the rug", allowing a patient to abuse his arthritic joint unless he is warned of the potential danger.

Summary and Conclusions

Over the past 17 years we have aspirated and injected arthritic joints of more than 8,000 patients a total of nearly 250,000 times. We encourage aspiration of all accessible arthritic joints for the diagnostic value of synovial fluid examination. Injection of minimal doses of corticosteroid suspension into inflamed arthritic joints, bursae, or tendon sheaths produces relief of pain and swelling for fairly prolonged periods of time, and reinjection after return of symptoms can reduplicate the effect repeatedly over many years of treatment.

Intra-articular steroid therapy has definite limitations, is useful when one or only a few joints are the major cause of disability, and must be only an adjunct to general or systemic therapy in most conditions. Adverse effects, such as infection following joint injection, or joint destruction following repeated injections, are rare but serious. Each must be watched for and treated promptly and adequately.

Intra-articular corticosteroid therapy has advantages over systemic steroid therapy in the infrequency of adverse effects and can be more readily discontinued without relapse than systemic corticosteroids. It is a local treatment, and a potent one.

Despite its limitations and potential dangers, we conclude that *no other form of treatment for arthritis has given such consistent local relief from pain to so many for so long with so few harmful effects.* We continue to use intrasynovial steroid therapy for the palliation of local inflammation from arthritis or related conditions in a steadily increasing number of satisfied patients.

REFERENCES

1. Hollander, J. L., et al: Hydrocortisone and cortisone injected into arthritic joints. *Jour Am Med Assn* **147:**1629, 1951.
2. Hollander, J. L.; Jessar, R. A.; and McCarty, D. J.: Synovianalysis, an aid in arthritis diagnosis. *Bull Rheumat Dis* **12:**263, 1961.
3. Hollander, J. L.; Reginato, A.; and Torralba, T. P.: Examination of synovial fluid as a diagnostic aid in arthritis. *Med Clin N Am* **50:**1281, 1966.
4. McCarty, D. J., and Hollander, J. L.: Identification of urate crystals in gouty synovial fluid. *Ann Intern Med* **54:**452, 1961.
5. McCarty, D. J.; Kohn, N. N.; and Faires, J. S.: The pseudogout syndrome. *Ann Intern Med* **56:**711, 1962.
6. Hollander, J. L., et al: Studies on the pathogenesis of rheumatoid joint inflammation. I. The "R.A.Cell" and a working hypothesis. *Ann Intern Med* **62:**271, 1965.
7. Hollander, J. L.: Intrasynovial corticosteroid therapy. In *Arthritis And Allied Conditions,* 7th edition. Philadelphia: Lea and Febiger, 1966, p. 381-398.
8. McCarty, D. J.; and Hogan, J. M.: Inflammatory reaction after intrasynovial injection of microcrystalline adrenocorticosteroid esters. *Arth & Rheum* **7:**359, 1964.

Dedication To Our Doctors

DOCTORS' DAY

MARCH 30, 1970



Doctors' Day is a special day observed each year to honor the members of the medical profession, both living and dead, who have devoted their lives to the art of healing.

The idea of Doctors' Day originated in Georgia in 1933 and was adopted by the Woman's Auxiliary to the American Medical Association in 1934. Since the analogy of the carnation is closely intertwined with medical science, the red carnation was chosen in 1949 as the symbol of Doctors' Day.

March 30th, the official date, commemorates one of the greatest discoveries for the alleviation of pain and suffering. On March 30th, 1842, Dr. Crawford W. Long first used ether anesthesia in surgery.

In recognition of the doctors' contributions to the people and to the communities they serve, the Heart Association of Maryland will dedicate its window to a display honoring Doctors' Day from March 23rd until April 6th.

Also in honor of Doctors' Day, a contribution will be made by our auxiliary to the American Medical Association Education and Research Foundation, to be divided equally between The Johns Hopkins University and the University of Maryland School of Medicine.

Mrs. Robert A. Reiter, President
Woman's Auxiliary to the
Baltimore City Medical Society

Mrs. Max R. English, Chairman
Doctors' Day

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on January 8, 1970 and took the following action:

1. Adopted the 1970 budget for recommendation to Council with certain stipulations regarding expenses of various departments of the Faculty;
2. Agreed to continue providing financial aid o a physician's wife and family, if the physician-member is totally incapacitated;
3. Deferred action again in connection with proposed Health Department Radiation Control regulations until more information is available;
4. Approved the mailing of a questionnaire to members regarding their use of Faculty facilities and services;
5. Approved the proposed Food and Drug Law as requested by the State Department of Health and Mental Hygiene;
6. Deferred action on a proposed feasibility study in connection with Medical Economics; and also deferred action on the AMA Study on Long-Range Planning on which comments have been requested;
7. Requested legal counsel to attend the next Executive Committee meeting at which time discussion would take place on filing an Amicus Curiae brief on a legal case dealing with conviction of an individual on the basis of information provided his attending physician;
8. Requested further discussion with representatives of the Governor's Commission on Law Enforcement in connection with a proposed questionnaire that would be mailed to physicians;
9. Agreed to a tentative agenda for a joint meeting with the Executive Committee of Hospital Council, Inc., and the Faculty's Executive Committee;
10. Approved for recommendation to the Council, nominees for (a) Blue Shield Board of Trustees (b) Blue Shield Medical Relations Committee (c) Blue Shield Reference and Appeals Committee and (d) Blue Cross Board;
11. Adopted for recommendation to Council a resolution on the Transportation of Emotionally Disturbed Patients;
12. Heard that the State Department of Health and Mental Hygiene is in the process of developing a "formulary" for use in treatment of Medicaid patients. The use of the formulary will be on a volunteer basis.

The Council of the Faculty met on January 22, 1970, and took the following action:

1. Approved appointment of an additional member to the Medical Advisory Board, Department of Motor Vehicles;
2. Approved requests of components dealing with recommendations of members for Emeritus Membership to the House of Delegates;
3. Waived 1970 dues for two members because of illness, at the request of the component society;
4. Approved changing the Annual Meeting dates for 1971 to April 28, 29 and 30; and for 1972 to May 3, 4 and 5;

5. Adopted the following recommendation of the Prince George's County Medical Society:
   "That the Faculty be requested to work for legislative changes through the General Assembly of the State of Maryland by virtue of which the defendant in torts would be permitted to have the final option as to whether he would be tried before a Judge or Jury";
6. Presented the "thought" behind the following resolution to an ad hoc committee for study and report to the 1970 Annual Meeting:
   "That the Faculty be requested to work for legislative changes through the General Assembly of the State of Maryland seeking to have the contingent fee method of payment between attorney and client made illegal"
   after it rejected adoption of this resolution;
7. Reaffirmed current policy that exhibitor space shall not be leased for the purpose of promotion of clinical laboratory services, whether owned or operated by lay persons or physicians;
8. Rejected a proposed resolution dealing with the Transportation of Emotionally Disturbed Patients, on the basis that this was a local problem and should be solved locally;
9. Submitted various names to the Blue Shield Board of Trustees for consideration by its Nominating Committee to (a) Blue Shield Board (b) Medical Relations Committee and (c) Reference and Appeals Committee;
10. Submitted three names to the Blue Cross Board of Directors for consideration by its Nominating Committee for election to the Board;
11. Approved the 1970 budget with the understanding that the Executive Committee will make a further report to the Council in March, 1970, with respect to various operations within the Faculty;
12. Heard Eugene Guthrie, MD, executive director of the State's Comprehensive Health Planning Agency, report the current activities of this group;
13. Heard the current status of the suit of Charles County physicians in connection with the hospital bond issue that has been petitioned to referendum in that county.

The Executive Committee met on January 22, 1970, and took the following action:

1. Discussed at some length library operations and deferred action on a request for additional personnel for the library until the February, 1970 Executive Committee meeting;
2. Referred to the Baltimore County Medical Association a request for addressing announcements in connection with a new medical group, inasmuch as this was a local issue.

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Laboratory Tests for Rubella and Their Interpretation

J. MEHSEN JOSEPH, PhD
HOWARD GARBER, MD
Division of Virology
Division of Communicable Diseases
Maryland State Department of Health

Rubella is a disease of major importance because of the high incidence of congenital defects found in infants whose mothers are infected, either clinically or inapparently, during early pregnancy. Because of this teratogenic potential of the rubella virus, and the unreliability of clinical diagnosis, rapid and reliable laboratory confirmation of recent infection is often required.[1]

Clinical diagnosis of a rubella-like illness can be confirmed only by virus isolation or demonstration of a fourfold or greater rise in rubella antibody titer in the patient's serum. Because of the considerable expense and time required to isolate and identify the rubella virus, this method has limited application. Also, failure to isolate the virus from clinical material does not rule out the recent or current rubella infection.[2, 3]

Serodiagnosis is the most reliable and practical means of confirming clinical rubella or detecting inapparent rubella in a pregnant woman exposed to rubella-like illness. Four methods are currently available for measuring rubella antibody: 1) hemagglutination-inhibition (HI), 2) complement fixation test (CF), 3) neutralization test (NT), and 4) fluorescent antibody test (FA).

In order to properly apply the serologic techniques and accurately interpret the data, one must understand the dynamics of virus excretion and antibody response. In clinical rubella, virus may be excreted from the throat as early as seven days prior to onset of rash and for seven to fourteen days after the rash appears. This means that a pregnant woman who claims exposure to rubella the day a rash appears on her child could actually have been exposed seven days earlier. Also, this fact must be considered to properly interpret serologic data as to the immune status prior to exposure.

In clinical rubella, HI antibody is detected in the blood 24 to 48 hours after the appearance of the rash. The titer rises rapidly and reaches a peak within six to twelve days after the rash appears. The antibody titer remains undiminished for several years or may show a two- to fourfold decrease. Practically 100% of the cases of rubella develop HI antibody and this antibody persists in the blood probably for life. Because of the rapidity with which HI antibody develops, blood specimens must be collected as near the day of onset or appearance of rash as possible in order to demonstrate a rise in titer. Where a second examination is indicated, the blood specimen should be taken seven to fourteen days after the first specimen is drawn.[4, 5]

The CF antibody is detectable in the blood approximately seven to ten days after the appearance of the rash. The titer peaks at 14 to 21 days (occasionally one month) after onset of rash. After peaking, the

titer falls rather rapidly and CF antibody may persist for only two to three years in most cases. Thus, the CF test is not useful in determining immune status. CF antibody fails to develop entirely in some patients; therefore, a negative CF test is of no diagnostic value. Only a positive titer with a significant rise between acute and convalescent sera is conclusive. The CF test is chiefly a back-up procedure to the HI test since the rise in CF antibody is slower and the peak titer is reached later. It is of value in showing the fourfold rise in titer which may not be evident with the HI test.[6]

Neutralizing antibody makes its appearance at approximately the same time as the HI antibody and shows a similar but lower titer rise. This test is no better than the HI test for serodiagnosis and requires about two weeks to complete.

FA antibody makes its appearance late in the first week of the illness and reaches peak titer by the 14th day. The FA test is a highly sensitive procedure but is most difficult to perform and therefore not routinely employed.[7, 8]

Tests for rubella are useful in the following circumstances:

1. To determine the immune status of pregnant women exposed to rubella, or to establish whether infection has resulted from the exposure
2. To diagnose suspected congenital rubella in the newborn child
3. To determine the immune status of prenatal patients, nurses and other female medical personnel of childbearing age prior to an exposure
4. To confirm, or rule out, rubella in a patient with a rubella-like illness
5. To determine immune status prior to administration of rubella vaccine.

Interpretation of Serologic Data

For the laboratory to select the most useful serodiagnostic procedures for detecting clinical or inapparent rubella infection and to accurately interpret the results, the physician must give the laboratory certain basic information with his initial request. This information should include, in addition to patient identification:

1. Estimated week of pregnancy
2. Date of onset of rubella-like illness, if any
3. Date of exposure to rubella, type of exposure —household or casual
4. Date blood specimen collected
5. If gamma globulin administered, amount and date.

A summary of the interpretation of serologic data in the different clinical circumstances is given below:

A. To determine the immune status of a pregnant woman exposed to rubella or to establish whether infection has resulted from the exposure—When the pregnant woman is exposed to rubella in her own household, several possibilities regarding the date of this exposure exist: (a) she was exposed seven days prior to onset of rash in her child; (b) she was exposed to the same source as her child and may have an inapparent infection; or (c) she herself was the primary case in the household.[9] Two blood specimens must be taken. The first specimen is taken as soon as it is known that she has been exposed and the second is taken 14-21 days later. If the first serum, which is tested immediately after collection, does not contain detectable HI antibody or a low level, the second blood should not be collected until 28 days after the first. This obviates the usual 14-21 day incubation period. Also, it is advisable to test the child or contact to determine whether or not the rash is caused by the rubella virus; occasionally it is not rubella.

The results may show any of the following:

(a) A fourfold or greater rise in the HI or CF titer or both between the first and second blood specimens is compatible with current rubella infection;

(b) If there is no change in titers in either the HI or CF tests between the first and second blood specimens and the titers are low, the findings are compatible with residual antibody from past infection;

(c) If the titers of the paired bloods are stable but extremely high, further studies are required to determine whether or not this represents peak antibody response to a current infection. This situation may exist if the first blood specimen is taken several weeks after the exposure;

(d) If no antibody is detectable in either specimen, the results are indicative of no immunity and no infection as a result of the exposure.

B. To diagnose suspected congenital rubella in a newborn child—Single specimens of blood should be taken from both mother and child. If the child is less than seven months old, a second specimen is required at seven to nine months of age.[10]

The presence of rubella antibody in the serum of infants up to approximately seven months of age may be due to transplacental transfer of maternal antibody, or may result from intrauterine infection. Persistence of an elevated HI antibody titer in the infant seven to nine months of age is compatible with congenital rubella. Determination of the class of immunoglobulin containing HI antibody activity can be used to establish congenital rubella in a serum specimen.

Rubella virus isolation from the newborn infant is confirmation of congenital rubella.

C. To confirm or rule out rubella in a patient with rubella-like illness—Acute and convalescent blood

specimens are required. The acute specimen should be taken within two to three days after onset of rash and the convalescent specimen seven to fourteen days later. A fourfold or greater rise in either HI or CF antibody titers is indicative of current infection.

D. To determine the immune status of prenatal patients, nurses and other paramedical personnel of childbearing age; and of others prior to administration of rubella vaccine—Usually only a single blood specimen is required. If the result of the HI test is reported as less than 1:8, the individual has no serologic evidence of past rubella infection and is probably susceptible to rubella. A titer of 1:8 is borderline. In both instances these individuals are candidates for the vaccine.

If the HI titer is 1:16 or greater in a healthy individual who has no clinical signs of rubella or history of very recent exposure, this person can be presumed to be immune.

Effect of Gamma Globulin on Antibody Titer

Occasionally the physician administers gamma globulin to a pregnant woman following her exposure to a rubella-like illness and then requests an antibody titer on the patient. The question immediately arises, "What effect does gamma globulin have on the antibody titer?" Studies have shown that the quantities usually administered may result in titers ranging from no detectable antibody to a maximum 1:16 in individuals without pre-existing antibody. Frequently, the resulting HI titer observed is 1:4 to 1:8. Obviously, one cannot determine the immune status in such cases except where there is no detectable antibody following administration of gamma globulin. This would be compatible with a lack of immunity. However, prior administration of gamma globulin does not interfere with the serodiagnosis of subclinical or clinical rubella since the antibody rise in the latter is substantial.

Specificity of Serological Response

Antibodies detectable by either the hemagglutination-inhibition, complement fixation, fluorescent antibody or neutralization tests are highly specific for rubella. Rubella antigens do not cross-react with antibody induced by rubeola, mumps, para-influenza, influenza, respiratory syncytial, adenoviruses or enteric viruses; infection by these viruses apparently does not result in a nonspecific anamnestic response of rubella antibody. Therefore, a significant rise in rubella antibody titer cannot be attributed to such a response.

A specific anamnestic response in a pregnant woman immune to rubella following her exposure to massive doses of rubella virus in a household contact might result in a two- to fourfold booster response in the mother.[11] However, this antibody is entirely of the IgG class and not IgM which develops only as a result of primary infection.[12]

Conclusion

In addition to the serologic test for syphilis and Rh typing, the rubella hemagglutination-inhibition test should be done routinely on all prenatal patients on initial visit to establish their immune status. Those who lack rubella antibody should be tested on each succeeding visit through the second trimester of pregnancy to detect subclinical rubella which may result from an exposure unknown to the patient. Thus, unnecessary anxiety on the part of both patient and physician can be avoided in most cases since 85% to 90% of adults are immune.

REFERENCES

1. Cooper, L. Z.: Rubella: A preventable cause of birth defects. *Birth Defects-Original Article Series* **IV**:22-35 (July) 1968.
2. Parkman, P. D., et al: Rubella virus-isolation, characterization and laboratory diagnosis. *Am J Dis Child* **118**:68-77 (Jan) 1969.
3. Whitmire, C. E., et al: Problems in detection of rubella virus in African green monkey kidney tissue culture. *Proc Soc Exp Biol and Med* **128**:253-257, 1968.
4. Stewart, G. L., et al: Rubella-virus hemagglutination inhibition test. *New Engl J Med* **276**:554-557, 1967.
5. Field, A. M., et al: A comparison of the hemagglutination inhibition test and the neutralization test for the detection of rubella antibody. *Lancet,* pp. 182-184 (July 22) 1967.
6. Field, A. M.: The occurrence of neutralizing and complement fixing antibodies in rubella. *J Hyg* **65**:409-421, 1967.
7. Best, J. M., et al: Serum IgM and IgG responses in postnatally acquired rubella. *Lancet,* pp. 65-68 (July 12) 1969.
8. Gordon, G. C., et al: Rapid diagnosis of rubella by fluorescent antibody techniques, International Symposium on Rubella Vaccines, London, 1968. *Symposium Series Immunobiol Standard* **11**:95-104. New York: Karger Company, 1969.
9. Horstmann, D. M.: First-trimester exposure to rubella. *JAMA* **204**:219-220 (Dec) 1968.
10. Dudgeon, J. A.: Congenital rubella. *Am J Dis Child* **118**:35-44 (Jan) 1969.
11. Enders-Ruckle, G.: Seroepidemiology of rubella and reinfection. *Am J Dis Child* **118**:139-142 (Jan) 1969.
12. Baublis, G. V., and Brown, G. C.: Specific response of the immunoglobulins to rubella infection. *Proc Soc Exp Biol and Med* **128**:206-210, 1968.

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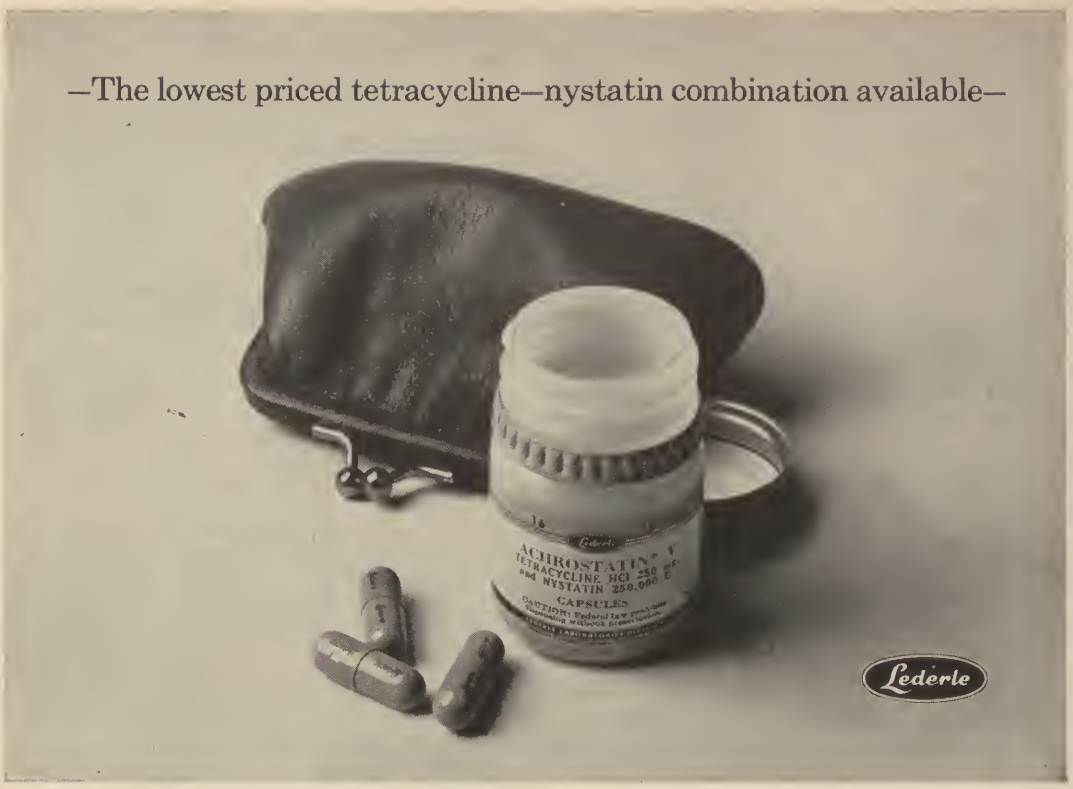
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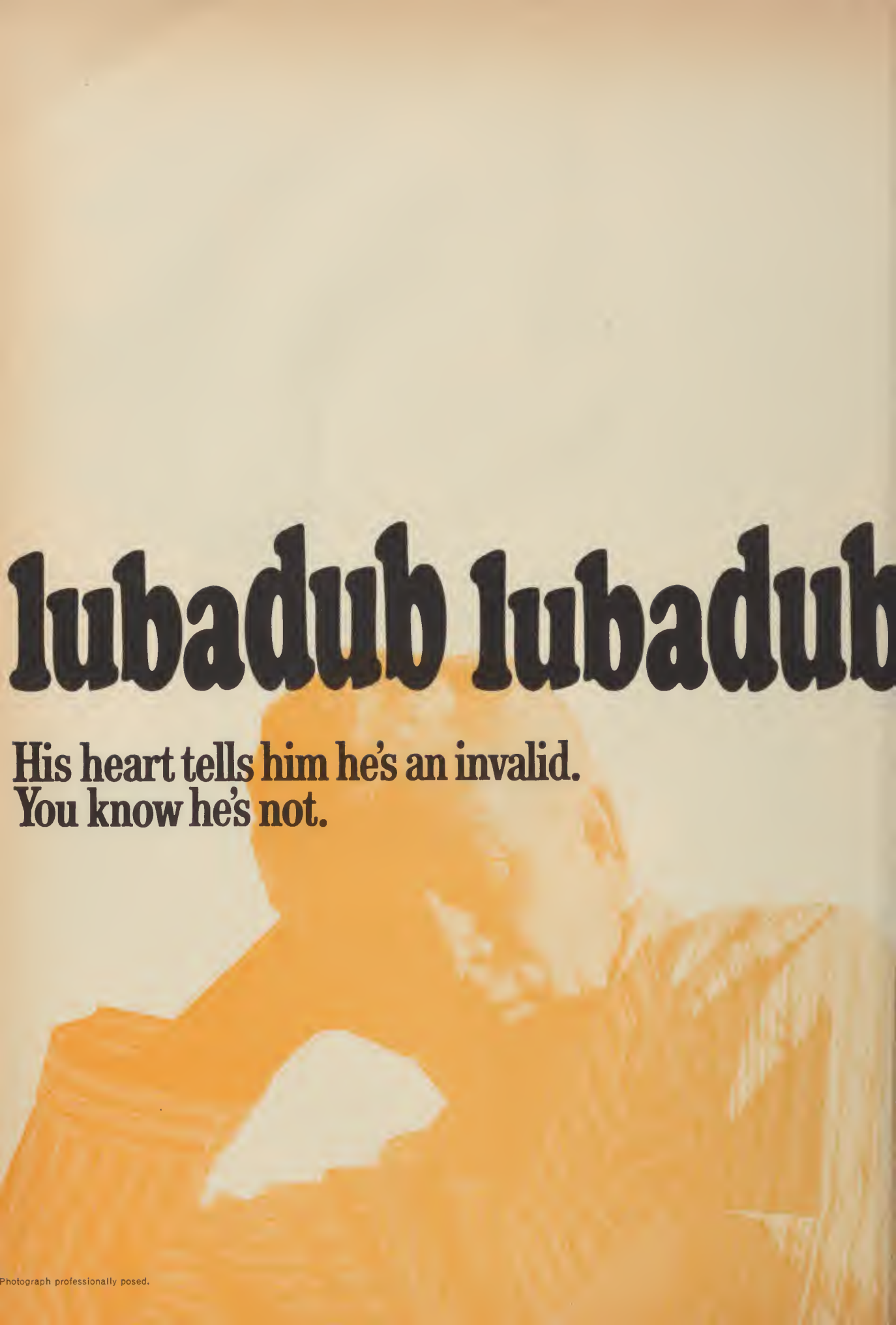
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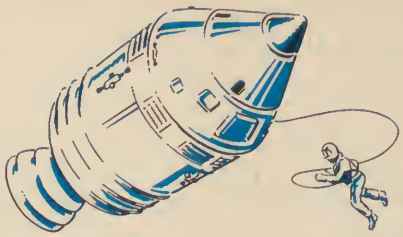
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Meeting Highlights

Seven of the members of the Board of Directors of the Baltimore City Medical Society met for their monthly meeting on January 13, 1970 at 4:30 PM at 1211 Cathedral St., Baltimore, Md. The meeting was called to order by John N. Classen, MD, president.

The minutes of the December 2, 1969 meeting were approved.

The first item on the agenda was a letter read to the Board of Directors from Timothy D. Baker, MD, chairman of the Medical Care Committee. In his letter, Dr. Baker explained that the Medical Care Committee, in its effort to broaden the scope of activities and make it an effective body, passed the following recommendation at the meeting on November 21, 1969. "The Committee requests that the next general mailing from the Society contain an open invitation for all members of the Society to write to the Chairman of the Medical Care Committee if they have interest in either becoming a regular member of the Committee or in becoming a 'corresponding member'."

Dr. Baker's letter further explained that a "corresponding member" would be a physician who, although he is interested in the problems of medical care in the city, is unable to attend regularly scheduled meetings of the committee. He would receive all minutes and other pertinent information and would be urged to submit to the chairman any comments or suggestions he may have.

After brief discussion, the Board of Directors approved the suggestion of Dr. Baker, thus a reminder will be included with the next general mailing of the society.

The next item on the agenda was the consideration of the Maryland Artificial Kidney Treatment Fund. William G. Esmond, MD, in a recent correspondence to the Board of Directors, sought the sanction of the Baltimore City Medical Society for support in the formation of a fund to aid patients in need of artificial kidney treatment. Dr. Esmond included in his correspondence the bylaws of this new charitable organization which he states is formed in the State of Maryland to assist indigent Maryland kidney failure patients. After much discussion by the Board, it was decided that definitive action on this matter would await further information from Dr. Esmond as well as the opinion of an authoritative advisory council.

The next item was a letter from John B. De Hoff, MD, chairman of the Committee of Tellers for 1969. Dr. De Hoff presented the following problems as being evident during the recent elections held by the Baltimore City Medical Society:

When the committee met to count the ballots, the members first discussed rules which they would accept to judge votes for validity or invalidity. Ballots were considered invalid if they fell into the following categories:

(a) Envelopes not signed in the proper fashion by the voting physician; (b) Mailing envelopes postmarked after the acceptable date; (c) The ballot itself signed or stamped or written on in any fashion which would mark it as unusual; (d) Excess number of spaces marked where more nominees were listed than a member could vote for; (e) Ballots marked "Vote for all but. . . ."

Certain ballots were filed incorrectly but were accepted as valid if they met the criteria of the instructions. For example, many physicians removed the signature leaf of the ballot envelope, folded it and included it in the envelope with their ballot. These were opened and if the physician was legally qualified to vote, the committee accepted his vote. This year, prior to examining the ballots, the committee elected to consider invalid any ballot that had excess spaces voted; Dr. De Hoff believes the committee,. next year,

should consider whether or not to allow the other votes on such marked ballots (if according to rules) to count. The tear flap of the ballot envelope in effect stated that ballots could be marked as desired. This probably meant "vote for whom you wish" rather than mark the ballot any way you wish. He also feels that ballots next time should say something to the effect that "vote by placing an X in the designated space opposite the nominee or candidate of your choice." This would lessen the number of sloppily completed ballots, some with lines, some with checks, some with Xs, some with indefinite other marks.

Finally, the Committee opened the envelopes, counted all the votes including those where there was no other candidate, authenticated the tally sheets with signatures of respective tellers, referred problem ballots to the chairman for decisions, and this year recounted one close contest.

Dr. De Hoff suggested that a way to remedy such problems would be to establish a tellers committee prior to the preparation of a ballot to minimize some of the above or some new problems which might arise. The Board concurred with this suggestion.

The next item on the agenda was the proposed election of Society members to Emeritus status. These include Alexander J. Schaffer, MD, member since 1932; Walter E. Fleischer, MD, member since 1947; Melvin H. Crocker, MD, member since 1947; and R. S. Penner, MD, member since 1967. After a brief discussion, it was decided that these members should be proposed for Emeritus status.

The Board considered and approved the waiver of dues for William J. Sawyer, Jr., MD, and Isaac Miller, MD, because of ill health.

There was no other old business and the meeting was adjourned at 5:30 PM.

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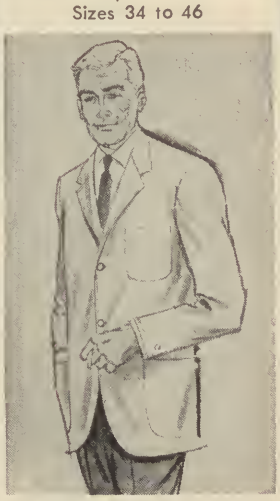


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AMA Priority Objectives:

Solutions to Nation's Major Health Problems

"We plant trees today so that others may have shade tomorrow." Burtis E. Montgomery, MD, chairman of the AMA Board of Trustees, recently quoted this Chinese proverb to illustrate that the accomplishments of today's physicians and medical societies should include the solution of eight of the most pressing health problems now confronting the nation.

As identified by the American Medical Association, they are:

The acute shortage of health manpower—the demand for health care has created an imbalance in the supply-demand equation of health professionals and other personnel. Increasing affluence, longer life, greater appreciation of good health care, and such government programs as Medicare and Medicaid have greatly increased the demand. Consequently, the AMA, in cooperation with the Association of American Medical Colleges, is urging all medical schools to increase their enrollment and offers its assistance in establishing new schools. Success of this approach to date is evidenced by 24 new medical schools created since World War II, raising to 101 the total number of schools now accepting students. Others are in the planning or construction stage, and most existing schools have increased their enrollment.

The AMA Council on Medical Education is cooperating with attempts of medical schools to reduce the length of medical training and is reviewing the time required by various specialty boards for certification of specialists.

The AMA Committee on Education for Related Health Professions and the AMA Council on Health Manpower are also stimulating a variety of programs to develop new physicians' assistants, new health care roles for nurses, and innovative steps to increase total productivity. The Association has adopted essentials of accredited educational courses and accredits programs for 13 different technologies. In addition, it endorses increased federal appropriations for both the schools and individual students.

Rising health care costs—the AMA is working closely with the American Hospital Association and hospital medical staffs to review every item of hospital costs in an effort to remove those items which should be supported by other means. Physicians are also being encouraged to eliminate hospital care or reduce it whenever possible and to use less expensive extended care facilities and home health care services.

The AMA is now preparing a public education program to illustrate how unrealistic demands for health care inflate costs.

Financing health care—the AMA supports a national health insurance plan based on tax credits and certificates that would enable all Americans to purchase comprehensive health insurance coverage. Its proposal would establish a sliding scale of tax credits depending on the individual's tax liability, and the credits would be applied to health insurance provided by private carriers.

Mental health—the AMA proposed the program that was enacted by Congress to establish a network of nationwide community mental health centers. The program involves close cooperation with the mental health administration and other experts to discover more efficient methods of treatment and rehabilitation that will allow the patient to return to productive work more quickly.

Pollution—the AMA Council on Environmental and Public Health has held several national conferences on the problem of pollution of the air, waterways and the land, and it is working closely with governmental and private agencies to ameliorate this growing health hazard.

Alcoholism and drug addiction—the widespread use of alcohol has been accomplished by millions of medically identifiable alcoholics. They suffer a type of drug addiction which requires medical therapy and which causes 50% of all fatal accidents and innumerable criminal acts. Consequently, the AMA Committee on Alcoholism and Drug Dependence continues to conduct a major educational program in this area, directed at both adults and youths.

Health care of slum residents—the AMA Committee on Health Care of the Poor, recognizing that the problem of health care in the slum is basically a problem of the slum itself, is conducting a series of studies and conferences with civic and social lead-

ers, and it is preparing specific recommendations to improve both the quality and delivery of health care in these areas.

Malnutrition—poor nutrition is more far-reaching than most people suspect. It covers not only the underprivileged but also the middle-income group, and relates strongly to education at all levels of society. The AMA has adopted an aggressive program to fight hunger and malnutrition; local societies are being encouraged to meet with community dietitians, dentists and other health specialists in resource seminars and to participate in area health surveys.

In addition, the AMA will publicize guidelines for the evaluation of malnutrition, examine the science of nutrition as part of formal medical education, seek development of a central coordinating agency for nutrition at a high level in the executive branch of government, urge development of urban and rural programs to provide health services with a nutritional emphasis, and evaluate current nutritional education in schools.

Dr. Montgomery, speaking in behalf of the AMA Board of Trustees, has asked each medical society to help implement these programs at both the state and local level. "Everything physicians do today to help find solutions to these eight major health problems will affect, in large or small part, what physicians of tomorrow will be able to accomplish," he said.

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Baltimore Association of Medical Assistants — Highlights

The Baltimore Association of Medical Assistants held its monthly meeting at the Medical and Chirurgical Faculty on October 14, 1969. Lionel A. Desbordes, MD, guest speaker for the evening, spoke on "The Contraceptive Pill".

Dr. Desbordes gave a very detailed, yet simplified account of the anatomy and physiology involved in the menstrual cycle of the female. Then Dr. Desbordes explained the action of the contraceptive pill and the expected side effects. During a brief question and answer period, Dr. Desbordes enlightened his audience to many of the controversies which have developed over the pill.

Dr. Desbordes was born in New Orleans, and received his BS degree from Dillard University, and his MD degree from Howard University and Medical School. He served his internship at D.C. General Hospital, and his residency at Freedmen's Hospital in Washington, D.C. He served in the Army Medical Corps for two years. Dr. Desbordes is certified by the American Board of Obstetrics and Gynecology, and is a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology. Presently Dr. Desbordes is in private practice in Baltimore and serves on the staff of numerous local hospitals.



Dr. Desbordes

Mrs. Frances Fairley, Mrs. Esther Luchinsky, Mrs. Rita Cobry, and Mrs. Peggy Bury recently passed the American Association of Medical Assistants Certification examination. All four certified medical assistants are members of the Baltimore Association of Medical Assistants and are employed by physicians in the Baltimore area.

The certification examination is offered to all medical assistants who have been employed for a minimum of three years by a physician in an office, hospital, or clinic. The examination consists of seven sections: Medical Terminology, Anatomy and Physiology, Human Relations and Ethics, Medical Law and Economics, Laboratory Orientation (Urinalysis, Hematology, Bacteriology, Immunology and Injections, Radiology, and Physiotherapy), Office Skills, and Accounting. These seven sections are each subdivided into two parts: Clinical and Administrative, but five total sections must be passed to become certified in either section.



Mrs. Cobry **Mrs. Fairley**

The newly elected officers for the Baltimore Association of Medical Assistants for 1970 are:

Peggy Bury—President
William Leiby—President-Elect
Lila Adams—Vice-President
Elva Edmonston—Recording Secretary
Valerie Hachtel—Corresponding Secretary
Frances Fairley—Treasurer
Rita Cobry—Representative to MAMA

The new advisor to BAMA was also elected. Newland E. Day, MD, will be the advisor and work with H. L. Wollenweber, MD, for the coming year. Dr. Day will serve in this capacity for a two-year term. He replaces the outgoing advisor, John Littleton, MD.

The chapters of the Maryland Association of Medical Assistants once again cooperated in a very successful Viet Nam Christmas project. The chairman for the project was Mrs. Peggy Bury, and the co-chairman was Mr. John Allen. Numerous cash contributions were given to support this project, and all the medical assistants contacted merchants in their area to solicit donations of goods to use as stocking stuffers. The items were packed and sent during the month of November, and Mrs. Bury happily reports that the boxes were received in Viet Nam in time for Christmas. The Chaplain to whom they were sent has acknowledged receipt of the presents. In his letter of

gratitude, the Chaplain expressed his thanks for the interest of the medical assistants in helping to make Christmas a little happier for the servicemen in Viet Nam.



Mrs. Bury

The Baltimore Association of Medical Assistants was able to aid a poor family during the Christmas season. Donations for the needy family were received by the Chairman of the project, Mrs. Peggy Bury, and a collection of usable clothing was also made. Bags of groceries were delivered to the family on Christmas Eve.

The Association also gave a Christmas present to an invalid lady as part of the project.

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Frederick County Medical Society

The Frederick County Medical Society held its January meeting at the Fredericktown Inn in historic Frederick on January 20. Following the customary social hour and a well-prepared steak dinner, the members heard Mr. Robert L. Burton speak about his work as Assistant Director in the Division of Vocational Rehabilitation in the state. His review of the definition of a disability under the present laws was most informative and helpful to the membership.

Mr. Burton was introduced by Mr. Thomas J. Tidwell, manager of the Social Security office in Frederick, Maryland, who reviewed the criteria necessary for making application for disability benefits. Despite the weather, the meeting was unusually well attended. Albert M. Powell, Jr., MD, newly elected president, conducted the business meeting.

Other officers of the society include Richard Holz, MD, president-elect; Ernest A. Dettbarn, MD, immediate past-president; Edward Koenigsburg, MD, secretary; Fred Baker, MD, treasurer; and LeRoy Davis, MD, newly elected member of the Executive Committee. Drs. Thurman Mott and Robert Crouch are serving unexpired terms on the Executive Committee. Delegates elected to Med-Chi are Drs. Thomas Reid and Charles Wright; alternates are Drs. Richard Fruth and Willis Riddick.

Dr. Powell announced the establishment of a Physician Procurement Committee with George I. Smith, Jr., MD, as chairman. This committee will serve to actively encourage physicians to practice in Frederick County and will work with local communities in their attempts to secure physician services.

It was decided to reactivate the scholarship fund for aiding medical students from Frederick County with their medical school expenses. This fund, which has helped several young people in the past, is composed solely of contributions from members of the county society.

In other business, a report was given by Charles Spicknall, MD, Frederick County Health Officer and Chairman of the Long-Term Care Committee appointed to study the present long-term care facilities available and needs for the future. The report received the endorsement of the society and the committee was commended for its many hours of effort over the past year. The details of the report will be made public in the near future.

It was announced by Dr. Powell that the February meeting would be devoted to general discussion of future programs of the society, purposes of the society as it relates to the community, and a more-or-less self-study of our society and its future goals.

Ernest A. Dettbarn, MD
Journal Representative

Doctors Take Note . . .

(Continued from page 6)

APRIL 12-18, 1970
INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS

6th World Congress and 18th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists: Americana Hotel, New York, New York.

APRIL 13-17, 1970
UNIVERSITY OF OKLAHOMA MEDICAL CENTER

Clinical Anesthesia—A review course in practical and safe methods: Oklahoma City, Oklahoma. Enrollment limited to physicians who are not specialists in anesthesiology but whose practice includes administration of anesthetics. Contact: Office of Postgraduate Education, University of Oklahoma Medical Center, 800 Northeast 13th St., Oklahoma City, Okla. 73104.

APRIL 14, 1970
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Postgraduate Course—Culdoscopy: New York city. Contact: New York University Postgraduate Medical School, 550 First Ave., New York, N.Y. 10016.

APRIL 14, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Medical Management of Hypertension: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Speaker: Francis J. Borges, MD.

APRIL 15, 1970
MARYLAND KIDNEY FOUNDATION

Seminar—Compensatory Growth of the Kidney: 5 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. 21201. Speaker: Ronald A. Malt, MD, Associate Professor of Surgery, Harvard Medical School; Associate Visiting Surgeon, Massachusetts General Hospital.

APRIL 16-18, 1970
MOUND PARK HOSPITAL FOUNDATION/DEPARTMENT OF MEDICAL EDUCATION, BAYFRONT MEDICAL CENTER/UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE/PINELLAS COUNTY MEDICAL SOCIETY/FLORIDA ACADEMY OF GENERAL PRACTICE

Postgraduate Course—The Pulse of Laboratory Medicine: Tides Hotel and Bath Club, Redington Beach (St. Petersburg), Florida. 18 accredited hours, American Academy of General Practice. Fee: $100. Contact: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

APRIL 17-19, 1970
TAYLOR MANOR HOSPITAL

Symposium—Discoveries in Biological Psychiatry: Baltimore. Distinguished internationally known speakers include: **Pierre Deniker, MD,** University of Paris, France; **John F. J. Cade, MD,** President of the Australian and New Zealand College of Psychiatrists, and Senior Associate in Psychiatry and Examiner in Psychological Medicine, University of Melbourne, Australia; **Jorgen F. Ravn, MD, PhD,** founder and Secretary General of the Scandinavian Society of Psychopharmacology, Middelfart, Denmark; **Hugo Bein, MD,** Basel, Switzerland; **Paul Janssen, MD,** Beerse, Belgium; **Roland Kuhn, MD,** Munsterlingen, Switzerland; **Albert Hofman, MD,** Basel, Switzerland; **Frank Berger, MD,** Princeton, New Jersey; **Nathan Kline, MD,** Director of Research, Rockland State Hospital, Orangeburg, New York, and Assistant Clinical Professor of Psychiatry, Columbia University College of Physicians and Surgeons, New York, New York; **John C. Krantz, Jr., PhD,** Emeritus Professor of Pharmacology, University of Maryland School of Medicine; **Chauncey Leake, PhD,** University of California, San Francisco Medical Center; **Irvin Cohen, MD,** Baylor University Medical School, Houston, Texas; **Tracy Putnam, MD,** Beverly Hills, California; **Lothar Kalinowsky, MD,** Columbia University College of Physicians and Surgeons, New York, New York; **Barry Blackwell, MD,** Group Director, Psychiatric Clinical Research, Wm. S. Merrell Co., Cincinnati, Ohio; **Frank J. Ayd, Jr., MD,** Editor and publisher of the International Drug Therapy Newsletter, Baltimore, Maryland; **Joel Elkes, MD,** Henry Phipps Professor of Psychiatry and Psychiatrist-in-Chief, The Johns Hopkins Medical School and Hospital, Baltimore, Maryland. Each speaker will discuss his personal discovery of an important drug and biological therapy important in the care and treatment of the emotionally and mentally ill. Contact: Symposium Secretary, Taylor Manor Hospital, Ellicott City, Maryland 21043.

Blacks Make Up Two Per Cent

Of Our Doctors

There are approximately 6,000 black physicians in the United States today—about 2% of the nation's doctors—and two medical schools graduate about 83% of them.

These figures are part of a study compiled by the National Medical Association Foundation in cooperation with the American Medical Association.

Other aspects of the study show:

- The highest concentrations of black physicians in the United States are in California, New York and the District of Columbia.
- The highest proportions of black physicians (39%) are involved in general practice; the remainder are specialists in various medical fields.

Over 73% of the black physicians (compared with 65% of all physicians) are involved in patient care.

Some 16% of all physicians are in advanced medical training programs compared with 9% of black physicians.

The study also showed that black physicians are less likely to practice in groups than physicians in general. Only 2% of the black physicians practice in groups, but 9.5% of all physicians have group practices.

Of the 4,805 black medical students who graduated in 1967 (the latest year for which figures are available), 2,186 (45.5%) were graduated from Howard University College of Medicine and 1,822 (37.9%) from Meharry Medical College.

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Significance of Intermediate Levels of Antitrypsin Deficiency in Pulmonary Disease

Data presented do not indicate a causal association between intermediate levels of alpha $_1$ antitrypsin deficiency and chronic obstructive lung disease, in contrast to the link observed between severe deficiency and emphysema.

Several reported studies have linked a severe deficiency of alpha$_1$ antitrypsin factor with obstructive lung disease. The deficiency is an inherited autosomal recessive trait; severe deficiency indicates homozygous inheritance of an abnormal gene, and intermediate levels indicate the heterozygous state.

With severe deficiency, exertional dyspnea is the predominant symptom of disease. Destruction of lung parenchyma and pulmonary vessels with impaired diffusing capacity suggest emphysema. In patients with intermediate deficiency, lung disease is not as clearly defined.

To assess the relationship between the intermediate deficiency state and pulmonary disease, two investigations were made. In one, the frequency of intermediate antitrypsin deficiency in a chest clinic population was compared with a control group. In the other, the clinical features of lung disease occurring in subjects with severe deficiency were compared with those of people with intermediate levels.

In comparing the frequency of antitrypsin deficiency in normal and diseased groups, sera were obtained from 51 healthy adult blood donors and from 146 consecutive unselected patients attending a chest clinic. The patients had little in common except chronic cough or dyspnea due to pulmonary disease. The majority suffered from chronic obstructive lung disease.

Of the 51 healthy individuals, three had intermediate values, as did 17 of the 146 clinic patients. The difference is not significant.

Clinical Comparison

In the second phase of the study, in patients with intermediate and severe antitrypsin deficiency, 13 chest patients with severely deficient levels and 18 with intermediate levels were compared as to clinical manifestation of lung disease.

Spirometric indices of obstruction and restriction were roughly comparable, but there was a striking contrast between the two groups with respect to clinical manifestations. Patients with severe deficiency had a clinical picture of primary emphysema with minimal chronic bronchitis. Several reported loss of weight with onset of dyspnea on exertion, the beginning of symptomatic pulmonary disease.

Thirteen of the 18 patients with intermediate levels had significant chronic obstructive lung disease. The pulmonary disease in the other five was varied and included inactive pulmonary tuberculosis, polycythemia rubra vera with hypoxemia, and mild chronic bronchitis.

In the severely deficient group, diffuse loss of vascular markings over both lower lung fields with

Martin H. Welch, MD, Mark E. Reinecke, MD, James F. Hammarsten, MD, and Clarence A. Guenter, MD. *Annals of Internal Medicine,* September, 1969 (**Vol. 71**, No. 3).

preservation of upper-lobe vessels was seen on X-ray and confirmed on lung scans.

One patient with intermediate deficiency had a daughter with severe deficiency. His chest X-ray film did not show hyperinflation or vascular attenuation, and lung scan showed minimal decrease over left apex and right base, with greater perfusion of lower than upper zones. The daughter had primary emphysema, with vascular decrease in the lower zone characteristic of severe deficiency.

Pathogenesis Unclear

Although it has been established that severe deficiency of serum alpha$_1$ antitrypsin is associated with frequent occurrence of pulmonary disease, the potential knowledge to be gained from this disease state has not been realized. The goal of investigation in this area must be the elucidation of pathogenetic mechanisms. Such knowledge may be of great value in the study of other forms of chronic obstructive lung disease.

A hypothesis suggests that alpha$_1$ antitrypsin protects the normal lung against the destructive action of proteolytic enzymes. Since protease inhibitors are not generally specific in their action, trypsin need not be the enzyme of pathogenetic importance in such a hypothesis. Because little is known about concentrations of alpha$_1$ antitrypsin in various body tissues, it should not be assumed that the serum levels *per se* are the critical factors in producing disease in deficient persons.

An alternative hypothesis is that normal aging is associated with metabolic turnover of connective tissue fibers of the lung. Under tensile stress this turnover may lead to enlargement of the air sacs with age. Deficiency of serum alpha$_1$ antitrypsin might hasten turnover and thus hasten the changes of aging, resulting in clinical emphysema.

Both hypotheses are in some ways plausible, but strong supporting data are not yet available. It is not clear that the relationship between antitrypsin deficiency and pulmonary emphysema is a causal one. Definitive research in this area must probably await a clear demonstration of the site of primary injury in lung disease associated with severe antitrypsin deficiency, and also improved definition of specific factors producing that injury.

Meanwhile, some speculation based on simple clinical observations is possible. If antitrypsin deficiency is a cause of lung damage, it would seem that an increased susceptibility to lung disease might be expected in the intermediate group, though not as great as that in severe deficiency. If this were so, a high prevalence of intermediate deficiency should be detected easily in a population of chest disease patients. However, in this study no significant difference was found between the normal and diseased population in the prevalence of intermediate values, suggesting that intermediate deficiency does not cause lung disease.

The hypothesis that severe deficiency causes disease by subjecting the lung to dissolution by proteases remains attractive, however. Possible sources of proteases which might damage lung tissue include macrophages and bacteria within the airways and alveoli, and leukocytes in the bloodstream. The site of injury would depend on the source of protease. Since pulmonary blood flow is normally greatest in the lower zones, a destructive action of proteolytic enzymes from intact or destroyed leukocytes within the pulmonary capillary bed could produce panacinar disease with a preference for the lower lobes. This hypothesis would be supported by demonstration of a primary vascular lesion by light or electron microscopy. Proteases released from bacteria or macrophages would be more likely to cause injury at the level of the respiratory bronchiole resulting in centrilobular emphysema.

It is possible that severe antitrypsin deficiency predisposes patients to such a destructive process, whereas intermediate levels provide adequate defense of the pulmonary parenchyma to prevent clinical manifestations of disease within the normal life span.

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Baltimore County Medical Association

Annual Meeting Notes

The annual meeting of the Baltimore County Medical Association was held on Wednesday, December 17, 1970 at the Tail of the Fox. The meeting was called to order by the President, Theodore Patterson, MD, who welcomed the members and their wives.

Wilmer K. Gallager, Jr., MD, Program Chairman, introduced Mrs. Ann Flaccavento, director of "The Roundelaires," an acappella choir from Catonsville, which provided the entertainment.

After dinner, the business meeting began with the report of the Secretary-Treasurer, who gave the auditing report. The Chairman of the Board of Governors followed with his report. Sidney Venable, MD, gave a brief summary of the board activities. Morris Reese, MD, gave the report of the Liaison Committee. Barbara Solomon, MD, the association representative to the Interagency Council on Smoking, reported the progress of their campaign and again asked for volunteers to set up more groups to help individuals who wish to quit smoking.

Melvin Davis, MD, informed the members about the special meeting of the House of Delegates. The election of officers took place immediately after the completion of the reports. By a unanimous vote the elected were: Wilmer K. Gallager, Jr., MD, president; John M. Krager, MD, vice-president; and Herbert Levickas, MD, secretary-treasurer. Elected to the House of Delegates were: Drs. Melvin Davis, Edward Krieg, D. D. Caples, H. Mueller and Margaret Sherrard.

Dr. Patterson presented the gavel to Dr. Gallager, who then delivered the presidential address. A Past-President plaque was presented to Dr. Patterson by the new president. The plaque acknowledged the many services rendered by Dr. Patterson to the association and the community of Baltimore County.

The Doctor's cane symbol of office was presented to the President by his father, Wilmer K. Gallager, Sr., MD. This is the first time in the history of the association where both father and son have served as president. Dr. Gallager, Sr., was president in 1948 and 1949, the only president ever elected to a second term.

Wilmer K. Gallager, Jr., MD, was graduated from The Johns Hopkins Medical School, and served his internship and residency in internal medicine at The Johns Hopkins Hospital. After two years as a Captain in the U.S. Army Medical Corps, he served as Chief Resident in internal medicine at St. Agnes Hospital. He is board certified in Internal Medicine and is on the staff at St. Agnes, Bon Secours and Good Samaritan Hospitals. He is a member of the American Society of Internal Medicine, the American College of Physicians and the Industrial Medical Association. During the past year he served as President of the medical staff of St. Agnes Hospital and Vice-President and Program Chairman of the Baltimore County Medical Association.

John M. Krager, MD, is a graduate of the University of Maryland School of Medicine, class of 1952. He interned at St. Joseph Hospital and completed his residency in Pediatrics at the University Hospital. He has a Masters in Public Health from The Johns Hopkins Medical School and is a Deputy Health Officer for Baltimore County.

Herbert Levickas, MD, graduated from the University of Maryland School of Medicine in 1946, and trained in internal medicine at St. Agnes Hospital. He is a past president of St. Agnes Hospital medical staff. He has practiced general medicine in Arbutus since 1950.

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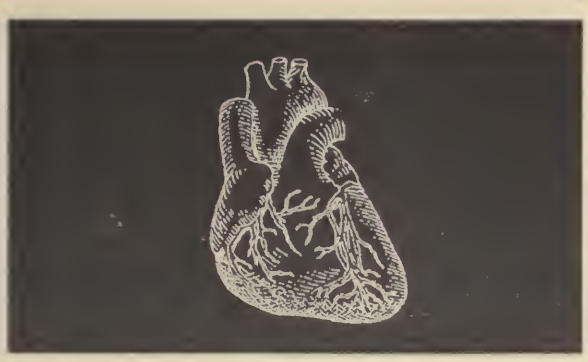
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JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

The Master's Two-Step Exercise Tolerance Electrocardiographic Test: *Part II*

LUIS F. GONZALEZ, MD
Baltimore

Recently, Dr. Master emphasized the need for his test in view of the fact that a resting EKG may be "negative" in 47% to 83% of the cases of classical angina pectoris. He further emphasized the need for an exercise tolerance test in men over age 35 whose resting EKG was within normal limits, based on the fact that approximately 600,000 deaths attributable to coronary artery disease occur every year in the United States. The need for an adequate history, physical examination, resting EKG, and the importance of having the individual stop should he develop shortness of breath, chest discomfort or classical angina pectoris was emphasized.

The basic disagreement in the literature concerns the amount of ST segment depression necessary to make the test positive. Most authors agree that an ischemic ST segment depression is a completely horizontal depression of the ST segment, or actually a downward-sag contour.

Master has emphasized that the majority of investigators require an ischemic ST segment depression of 1 mm or more, and that whereas this in general is correct, he advises that a depression of more than ½ mm be considered abnormal until it is proven otherwise.

Elevation of the RST segment above the resting EKG value should be considered as ischemic or a positive response. This change usually appears in leads in which a Q wave has been present, and several of these patients have been found to have ventricular aneurysms.

A good deal of doubt exists concerning the significance of post-exercise T wave inversion. Most investigators agree, however, that inversion of a T wave equal to or greater than its previous height should be considered abnormal. Those T waves which in the resting EKG are inverted and subsequent to exercise become positive should also be considered as a positive response to exercise. Master emphasized that the responses described above other than the ST depression usually appear with ischemic depressions of the ST segment; consequently, this remains the best criterion for abnormal responses. He believes that junctional ST segment depressions "if near ischemic", have a definite significance.

At the 1969 annual meeting of the American Medical Association, Dr. Master presented data which appear to establish the effectiveness of the two-step test in the prediction of the natural history of coronary artery disease. In 47 of 50 patients in his study who have died since 1955, the correlations between the results of the two-step exercise test and the findings at autopsy were excellent. He summarized these data by stating, "It is logical to conclude that a correlation exists between the positive two-step test which revealed a 1 mm ischemic depression in the RST segment, and the findings at death of diseased coronary arteries."

The technique of a double standard Master's two-step exercise test used by the Metropolitan Life Insurance Company has been described by Robb, Mattingly, and Marks. Emphasis is given to the standard two-step stairs, an EKG stylus that makes tracings with distinctly described deflections and seg-

ments, and the use of the Master's tables for the test.

The first of these tables has been reproduced in the April 1967 issue of *Diseases of the Chest.* Whereas suction electrodes are usually used for the precordial leads, the advisability of using strap chest electrodes should be emphasized, particularly in individuals with hairy chests.

Precordial leads should be clearly marked on the chest wall to make sure that the same precordial level is used for each specific lead, and to avoid erroneous placement on different occasions during the test. The subject should be made to carry the cable and be instructed not to stop the trips if one of the leads becomes loose. Tracings should be recorded immediately, one, two, four, six, eight and ten minutes after exercise, and if necessary, at five-minute intervals thereafter until the tracing has returned to the pre-exercise state. The so-called immediate recording should be completed within two minutes after the end of the exercise. Routine leads should be V5, V6, V4, 2, a VR, a VL, and a VF, in that sequence. Each lead should contain at least five consecutive cycles having deflections and segments suitable for interpretation. An adequate baseline may be obtained by having the subject withhold respiration while the tracings are being recorded. The subject should be instructed to avoid motions of the eyelids, toes, or fingers.

The selection of the individual who is to undergo the test is of critical importance, and there is no justification for carrying out the test on an individual who has had a myocardial infarction six months earlier, irrespective of electrical stability recorded electrographically.

The test should not be carried out on individuals who have an electrically unstable EKG at rest or have evidence of ischemia at rest. Careful selection of the subject will avoid criticisms, such as those offered by Freidberg and co-workers, subsequent to the death of an individual who had undergone the test. This specific incident has received wide publicity, and has resulted in considerable criticism of a test which, if performed within the framework described by Master and co-workers, is safe and informative.

Emphasis on the safety of the test when performed as described has been presented in the October 13, 1969 issue of the *Journal of the American Medical Association.* The advisability of carrying out this test in individuals who present a history of unequivocal angina pectoris but have a complete normal EKG at rest, or an individual who describes a history that is equivocal or atypical for angina, was described in April 1967 in *Moderate Concepts of Cardiovascular Disease,* and re-emphasized in the *American Journal of Cardiology,* February 1969.

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National Auxiliary President To Speak

An honored guest and speaker at our state auxiliary's annual convention will be Mrs. John M. Chenault of Decatur, Alabama. The convention will be held April 1 and 2 at the Sheraton Belvedere Hotel in Baltimore. Mrs. Chenault will address the luncheon gathering on Thursday, April 2.

Mrs. Chenault was installed as 1969-1970 president of the Woman's Auxiliary to the American Medical Association at the 46th annual convention on July 16, 1969, in New York city. She has been auxiliary president since April 1968, completing the term of the late Mrs. C. C. Long. She has served the national auxiliary as president-elect, bylaws chairman, first vice president, historian and director.

Other national positions she has held include rural health chairman, membership chairman, *Today's Health* chairman, program chairman, and member of the finance, nominating, structure review and health manpower committees. She has been an auxiliary member since 1946 and has served both her state and county auxiliaries in many capacities. She was Alabama state president in 1954-55, and was a two-time president of her county auxiliary. She has been a member of the state auxiliary board since 1948 and was made an honorary member of the state auxiliary in 1966.

Belle Montgomery Chenault is a graduate of the University of Alabama where her father is professor emeritus of organic chemistry. She met her husband while he lived in the home of her parents as a student at the university and they were married in 1941. The Chenaults have five children: Alice Chenault Maurer, biology instructor at Florida A & M College, Tallahassie, Fla.; Belle Chenault Morlok, high school English and music teacher, Birmingham, Ala.; John, Jr., a student at the University of Alabama; Leigh, 10, and Martha, 7.

Mrs. Chenault has always been a dedicated worker in her community. Her special interests include the Girl Scouts (she served as council president from 1956 through 1959 and is presently on the Board of Directors and finance committee); the DAR; Colonial Dames of the XVII Century; the Garden Club of Alabama; Decatur Mothers Club; League of Women Voters; Woman's Chamber of Commerce; PTA and County Mental Health Association. She has been a Red Cross water safety instructor, and is a member of the Baptist church, and a former Sunday school teacher.

She also is a member of Phi Beta Kappa, Kappa Delta Pi, Alpha Lambda Delta and Mortar Board honoraries, Zeta Phi Eta professional speech sorority, the American Association of University Women and Kappa Delta social sorority of which she is past alumnae association president. She is a past president of the Southern Medical Association Auxiliary.

Dr. Chenault is a member of the Board of Trustees of the American Medical Association and is chairman of the Board of Censors of the Medical Association of the State of Alabama, which also functions as the state board of medical examiners and the state committee of public health.



Mrs. Chenault

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Woman's Auxiliary—Preliminary Program

21st Annual Meeting April 1 and 2, 1970 Belvedere Hotel

Wednesday, April 1, 1970—Hospitality Room will be open Noon-6:00 PM)

2:00 PM REGISTRATION—Red Room, 2nd Floor
Mrs. Percy H. Sutley, Chairman

2:30 PM PRE-CONVENTION BOARD MEETING—Red Room, 2nd Floor
Mrs. Wallace H. Sadowsky, President—Presiding
Business Meeting

5:30-7:00 PM HOSPITALITY NIGHT—Charles Room, 1st Floor
Faculty members and their wives

7:30 PM INTERNATIONAL DINNER AND ENTERTAINMENT—Ballroom, 12th Floor
Mrs. Leopoldo Gruss, chairman
Exhibits and cash bar open at 6:30 PM
(Reservations for tickets, $10 each, including gratuity, must be received by Reservations Chairman, Mrs. José F. Martinez, 2307 Ravenview Road, Timonium, Md. 21093, by March 26, 1970. Guests welcome. All are encouraged to wear native costumes.)

Thursday, April 2, 1970—(Hospitality Room will be open 9:00 AM-6:00 PM)

8:30 AM PAST PRESIDENTS' BREAKFAST—Maryland Room, 2nd Floor
Mrs. H. Leonard Warres, Chairman

9:00 AM REGISTRATION—12th Floor
Mrs. Percy H. Sutley, Chairman

COFFEE HOUR
Mrs. James L. Garey, Hospitality Chairman

10:00 AM GENERAL SESSION—Assembly Room, 12th Floor
Mrs. Wallace H. Sadowsky, President—Presiding

PRAYER AND PLEDGE—Mrs. Raymond M. Yow, President-elect

GREETINGS—Richard A. Young, MD, Advisor to the Auxiliary and Chairman, Public Relations Committee, Medical and Chirurgical Faculty

RESPONSE—Mrs. Elmer G. Linhardt, 1st Vice President

PRESENTATION OF THE CONVENTION CHAIRMEN—Mrs. R. Kennedy Skipton and Mrs. Max R. English

ROLL CALL OF DELEGATES—Mrs. Edgar E. Folk, III, Recording Secretary

CONVENTION RULES OF ORDER—Mrs. Karl F. Mech, Parliamentarian

CREDENTIALS—Mrs. DeWitt E. DeLawter, 2nd Vice President

MINUTES OF THE 1969 SEMIANNUAL MEETING—Mrs. Karl F. Mech, Chairman, Reading Committee

REPORT OF TREASURER—Mrs. S. G. Sullivan

PRESENTATION OF BUDGET—Mrs. M. McKendree Boyer, Chairman, Finance Committee

NECROLOGY—Mrs. Robert Kabo

INTRODUCTION OF HONORED GUESTS—Mrs. Wallace H. Sadowsky, President

PRESENTATION OF PRESIDENTS OF THE COMPONENT AUXILIARIES—Reports distributed in printed form

PRESENTATION OF AUXILIARY OFFICERS AND COMMITTEE CHAIRMEN, 1969-1970—Reports distributed in printed form

SPECIAL REPORTS—

Mrs. Leroy B. Buckler, President of the Univ. of Md. Chapter Woman's Auxiliary to the Student American Medical Association (WA-SAMA)

Miss Linda Rush, President, The Future Nurse—Health Careers Club of Maryland

Report of the President—Mrs. Wallace H. Sadowsky

COURTESY RESOLUTIONS—Mrs. Martin E. Strobel

REPORT OF NOMINATING COMMITTEE—Mrs. George S. Malouf, Chairman

ELECTION OF OFFICERS—
INSTALLATION OF OFFICERS—Mrs. John M. Chenault, President, Woman's Auxiliary to the AMA

PRESENTATION OF GAVEL—Mrs. Wallace H. Sadowsky

INAUGURAL ADDRESS—Mrs. Raymond M. Yow

Recess

11:30 AM SHERRY HOUR—Ballroom, 12th Floor
Mrs. James L. Garey, Hospitality Chairman

12:30 PM LUNCHEON—Ballroom, 12th Floor
(Reservations for tickets $4 each, including gratuity, must be received by the Chairman, Mrs. S. G. Sullivan, 419 Oak Lane, Baltimore, Md. 21204, by March 26, 1970. Reservations limited. Physicians are invited.)

INVOCATION—Dr. Martin M. Weitz, Director, Center for Inter-Faith Studies, Lincoln University, Penna., and Rabbi, Temple Adas Shalom, Havre de Grace, Md.

PRESENTATION OF HONORED GUESTS—Mrs. Wallace H. Sadowsky, President

GREETINGS—Russell S. Fisher, MD, President, Medical and Chirurgical Faculty

GUEST SPEAKER—Mrs. John M. Chenault, Decatur, Alabama, President, Woman's Auxiliary to the American Medical Association

KEYNOTE SPEAKER—Matthew Debuskey, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine

PRESENTATION OF AWARDS—Mrs. Elmer G. Linhardt, Chairman, AMA-ERF

PRESENTATION OF PRESIDENT'S PIN—Mrs. Wallace H. Sadowsky, President

PRESENTATION OF PAST-PRESIDENT'S PIN—Mrs. H. Leonard Warres, Immediate Past President

ADJOURNMENT

3:00 PM POST CONVENTION BOARD MEETING—New Orleans Room, 2nd Floor
Mrs. Raymond M. Yow, President, Presiding

6:15 PM MEDICAL & CHIRURGICAL FACULTY ANNUAL PRESIDENTIAL RECEPTION AND DINNER—Blue Crest North, Reisterstown Road (Buses leaving from Belvedere Hotel)
(Contact Faculty Office for reservations)

(See your official program for a list of Convention Committee Chairmen)

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY
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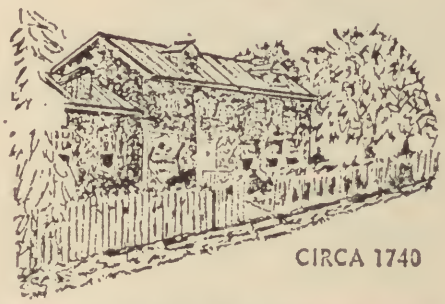
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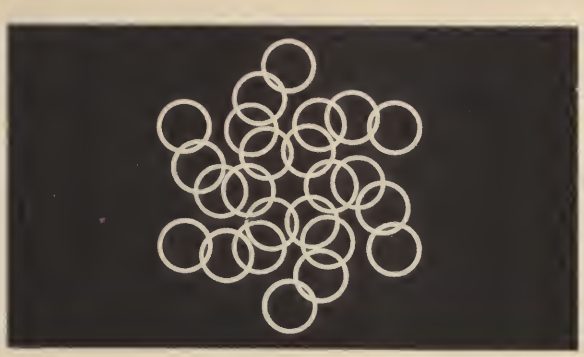
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Admissions to the Alcoholic Rehabilitation Unit of Crownsville State Hospital

GREGORY S. MESTANAS Staff Psychologist Crownsville State Hospital

The Division of Alcoholism Control of the Department of Mental Hygiene, in its annual report for 1968 entitled "The Year of the Alcoholism Law", stated that "More alcoholics than ever before entered the state mental hospitals, although current statistics are not yet available."

Demographic data collection, statistical analyses, and qualitative evaluations are integral parts of every alcoholism program. Decisions concerning assignment of personnel, expenditures, and treatment programs are almost entirely contingent upon statistics. This report is a statistical comparison of the number of admissions to the Alcoholic Rehabilitation Unit of Crownsville State Hospital for ten months prior to and ten months following the implementation of the Comprehensive Intoxication and Alcoholism Control Act in the State of Maryland to ascertain if the increase in admissions, reported by the Department of Mental Hygiene, is significant as it pertains to one state institution.

As of July 1, 1968, when the Comprehensive Intoxication and Alcoholism Control Act went into effect, public inebriation is no longer considered a criminal offense. With the passage of this new law, few police officers were sure of their position in dealing with inebriates; therefore, few drunks were taken to court or even arrested during July and August 1968, the first two months following enactment of the law. For this reason, ten-month periods, rather than twelve-month periods, were selected for comparative study. These periods were subdivided into monthly admissions which were then further divided into New Admissions and Readmissions in order to separate the individuals who were admitted for the first time from those who had been admitted before.

This study is based on 1,892 total admissions from September 1, 1967 through June 30, 1968, and 2,191 total admissions from September 1, 1968 through June 30, 1969. These figures do not refer to absolute numbers of different individuals since readmissions were also considered. Also, the numbers do not include returns from "elopements", "trial visits", or transfers to the Alcoholic Rehabilitation Unit from other units of the hospital. Only patients formally admitted to the hospital and assigned to the Alcoholic Rehabilitation Unit were included (see Table 1).

It is interesting to note that the total number of admissions from January 1969 through June 1969 significantly exceeds the number tabulated for the corresponding months in 1968.

The range for readmissions for 1967 to 1968 is 90 to 164, whereas readmissions during the following year ranged from 118 to 187. The number of readmissions rose steadily during the ten-month period from September 1968 through June 1969, an increase over and above the number recorded for the previous year.

Table 2 reflects the means, standard deviations (SD), and the values of t calculated on two small uncorrelated samples for new admissions, readmissions, and total admissions taken from both ten-month periods. The t tests were carried out on the means of the samples for the purpose of establishing the difference between the two. On the average, 66.5 individuals were admitted to the Alcoholic Rehabilitation Unit for the first time during the months September 1967 through June 1968 compared with 71 from September 1968 through June 1969. The difference between these means ($t = .878$) is not significant.

Table 1: Monthly Admissions to the ARU

New Admissions	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June
Sept. 1, 1967-June 30, 1968	62	51	70	68	67	57	72	66	77	75
Sept. 1, 1968-June 30, 1969	74	84	50	50	78	69	74	70	95	65
Readmissions										
Sept. 1, 1967-June 30, 1968	90	102	102	128	115	100	139	133	154	164
Sept. 1, 1968-June 30, 1969	118	144	133	125	138	130	169	163	187	174
Total Admissions										
Sept. 1, 1967-June 30, 1968	152	153	172	196	182	157	211	199	231	239
Sept. 1, 1968-June 30, 1969	192	228	183	175	216	199	243	233	283	239

Table 2: Means and Standard Deviations for Admission During September 1967-June 1968 and September 1968-June 1969

N = 10
d.f. = 18

	Year before the law		Year after the law		
	Mean	S.D.	Mean	S.D.	t
New Admissions	66.5	6.60	71.0	13.36	.878
Readmissions	122.7	23.67	148.1	22.26	2.308
Total Admissions	189.2	30.27	219.1	35.62	2.062

With regard to readmissions, on the average, 122.7 patients were readmitted during the ten months prior to July 1, 1968, and 148.1 for the same ten months in the following year. The value of t in this case is 2.308 which is significant at the .05 level of confidence.

It is important to note that while both the number of new admissions and the number of readmissions were higher during the period following July 1, 1968, the readmissions greatly increased whereas there was no great significance in the increase of new admissions. In essence, the percentage of individuals with alcohol problems did not significantly increase, but the same persons reappeared more often at the unit.

Discussion

The above results indicate the possibility that Maryland's Comprehensive Intoxication and Alcoholism Control Law may have affected the number of admissions to Crownsville State Hospital. If this is true, the law did not seem to affect the number of new admissions but, rather, those individuals who were known alcoholics, possibly indicating that once the members of the police force fully understood the law, they then started enforcing it. Many individuals previously arrested and imprisoned were brought to the hospital instead.

The law provides for detoxification of inebriates usually in a general hospital. Following detoxification, the individuals are transferred to a state hospital. General hospitals only recently fulfilled their role of accepting these functions. Efforts are being made by the Division of Alcoholism Control of the Department of Mental Hygiene to bring to the attention of other agencies the need to share the responsibility of helping the alcoholic and creating new facilities for this purpose.

The significant increase in readmissions to Crownsville may be the result of an individual's desire to return to the place where he first received treatment. The hypothesis here is that many alcoholics who experience difficulty in controlling their drinking, or who are homeless, ask to be readmitted to the hospital. If this plays a part in the increasing number of readmissions, it is not encouraging. The number of beds in the Alcoholic Rehabilitation Unit and the personnel have not been correspondingly increased. As a result, the treatment of alcoholic individuals could become less adequate.

Further research is required to discover the factors affecting this increase in admissions of alcoholics who have been admitted to the unit for one or more times.

Implications

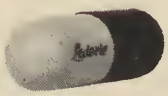
There is no concrete evidence to indicate that the number of alcoholics is increasing in the community, but there seems to be evidence that the alcoholic, who has previously been admitted to a state hospital for treatment, tends to return to drinking and then is readmitted. This does not imply, necessarily, that the treatment of alcoholics is totally ineffective; there are many alcoholics who after treatment, either by themselves or with the help of community agencies, maintain sobriety. It appears, however, that at this time many alcoholics, once they "slip", seek hospitalization. On the other hand, many agencies appear to be unable to cope with an alcoholic and seek to have him admitted if the problem is beyond their scope. In many instances hospitalization is not necessary and it is recommended that the alcoholic's family, private physician, or general hospitals, detoxification centers, shelters, half-way houses, and other facilities in the community can and should assist at the moment of crisis so that the alcoholic can get help without being hospitalized.

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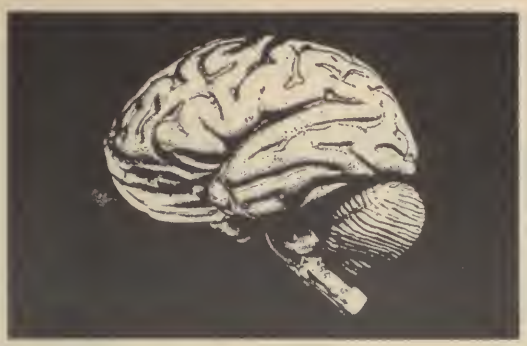
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Maryland State department of mental hygiene

Is There A Revolving Door?

Data from a study being prepared on Maryland's five state-operated mental hospitals indicate that the belief that many of the alcoholics admitted to these facilities return repeatedly is erroneous. During the four years ending June 30, 1968, 9,932 persons with a primary diagnosis of alcoholism accounted for a total of 16,818 admissions. Of these 9,932, 6,863 (or 69.1%) were hospitalized once during this period and 1,640 (or 16.5%) were admitted twice. Only 465 (or 4.7%) had five or more admissions. There was an average of 1.69 admissions per person.

The distribution of these individuals by race, sex, and number of admissions is shown in the following table:

	Total	White Male	White Female	Nonwhite Male	Nonwhite Female
Number of Admissions	**16,818**	**10,908**	**1,507**	**3,801**	**602**
Number of Persons Admitted	**9,932**	**5,993**	**1,017**	**2,451**	**471**
Average Number of Admissions	**1.69**	**1.82**	**1.48**	**1.55**	**1.28**
1 Admission	**6,863**	**3,975**	**778**	**1,729**	**381**
2 Admissions	**1,640**	**1,015**	**145**	**416**	**64**
3 Admissions	**653**	**430**	**48**	**159**	**16**
4 Admissions	**311**	**217**	**14**	**73**	**7**
5 Admissions	**151**	**106**	**10**	**33**	**2**
6 Admissions	**115**	**88**	**6**	**20**	**1**
7 Admissions	**51**	**43**	**4**	**4**	**—**
8 Admissions	**40**	**28**	**3**	**9**	**—**
9 Admissions	**29**	**23**	**3**	**3**	**—**
10 Or More Admissions	**79**	**68**	**6**	**5**	**—**
Rate *	**419.8**	**614.7**	**99.9**	**1,476.5**	**241.5**

Proportionally, nonwhite rates were more than twice as high as comparable figures for both white males and females. In part, this was related to the greater availability and use by the latter group of alternate treatment resources. Also, Negroes are hospitalized at an earlier illness stage as evidenced by a lower median age, a higher proportion of admissions for acute alcoholism and a smaller average number of admissions per person. This would appear to indicate varying incidence rates of the different alcoholism levels, as well as selective handling by police and other commitment sources.

Alcoholics are currently estimated to occupy one out of every nine state mental hospital beds and to account for a majority of all admissions. These figures represent a continuing substantial increase in recent years. While it is not known whether or not these data reflect a growing total number of alcoholics, most of this rise in admissions for alcoholism has been concentrated in age groups under 45. It would therefore appear that this upward trend will continue if present conditions persist. One possible alternative is the development of preventive programs, particularly among young state residents, concurrent with the large scale expansion of coordinated, community centered treatment facilities.

** Number of persons admitted per 100,000 estimated population 18 years of age or older in specified race-sex group.*

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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Cervical Spine Injuries

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These injuries generally fall into two categories: acute, catastrophic trauma, which is often associated with gross weakness in the extremities; and the more common chronic states found with soft tissue injury, disc protrusions and osteoarthritis. Only the first group will be considered here.

In civilian practice, the overwhelming majority of cases result from closed injuries.

Mechanisms

Violent neck trauma usually occurs in three settings: 1. diving injuries, 2. automobile accidents and 3. falls.

Force may be transmitted from the skull to the cervical spine in a linear fashion with a vertical compression fracture. More commonly, the neck is bent acutely with a fracture dislocation (Fig. 1). These occur preferentially at the C_5-C_6 and C_6-C_7 levels and usually result from acute flexion rather than extension. In 15%-20% of cases, films will be essentially normal. In some of these, vascular effects are prominent, in others, spontaneous reductions occur after hyperextension injuries, or lower cervical spine injuries are missed because of the failure to obtain adequate films. The spinal cord may be transected with devastating injuries. However, these are uncommon and at operation one usually sees a cord of relatively normal appearance, or one showing slight swelling or small contusions. Occasionally, the cord is grossly soft and exudes through the dural opening. Sizable extradural hematomas and disc protrusions do occur and cause cord compression, but these are rare enough that one is not justified in carrying out routine laminectomies in order to search for these masses. In cases coming to postmortem examination, the prime pathology is almost always found in the cord. Edema and hemorrhage are present and are characteristically in a central position; these often extend up and down the cord over several segments. The central site plus the absence of gross lacerations with closed injuries point to the fact that a prominent vascular component is often present initially.



Fig. 1: Fracture-dislocation: C_4 on C_5. The flexion deformity is associated with the most common type of severe injury.

Clinical Aspects

At the time of the first examination, two major aspects should be considered: 1. the stability of the spine and the need for reduction and fusion, and 2. the existence of compression on or swelling of the cord and the need for laminectomy. Often, no neurological changes are found and one is concerned solely with the mechanical aspects.

Meticulous, neurological examinations are mandatory and these should be repeated at frequent intervals. Many of the maneuvers which have been designed to relieve neurological defects remain controversial; however, few neurosurgeons would challenge the general usage of decompressions in the face of advancing neurological changes nor reliance on conservative means when the neurological status is improving.

The specific changes cannot be categorized here but several aspects may be noted briefly. Evidence of focal damage in the cord should be considered. An anterior mass or a vascular lesion may be suspected if complete or marked motor loss occurs with preservation of significant numbers of sensory (particularly posterior column) fibers and may, in conjunction with appropriate roentgenographic changes, lead to an operation. Lateralizing findings in the form of a Brown-Séquard syndrome may also prompt an exploration—again when matched with bony changes.

Disproportionate weakness in the upper extremities is found in a minority of cases of quadraparesis with cervical spine injury. Its evaluation has changed radically in the last decade. Schneider et al [3] have shown that the usual cause is not nerve root damage but a central cord injury with hemorrhage and softening at a point where the inner motor fibers (and perhaps anterior horn cells) for the upper extremity are damaged before the more superficial motor fibers which pass to the lumbar and sacral areas. The establishment of this distinction is of great importance since the diagnosis of central cord injury, by itself, stands as contraindication to operative intervention.

Diagnostic Studies

It is necessary to take full cervical spine films on patients who have sustained enough neck trauma to prompt a visit to the Accident Room since it is easy to miss fracture-dislocations or other serious malalignments on routine clinical examination. The initial films are often of poor quality, and unusual perseverance is often required. Adequate visualization of the lower cervical spine is time consuming and it is often good practice to pass a sheet about the shoulders to apply caudal traction as the head is tilted down 30° to 40°. Views through the axilla will also help in this situation.

Injuries at C_1-C_2 form a well-defined group and it is necessary to visualize these vertebrae clearly on lateral films and on views taken through the open mouth and to pay particular attention to the position of the odontoid process.

Oblique films should be made routinely to visualize fractures through the facets. Laminograms are needed occasionally in difficult cases.

In reviewing the film, such obvious changes as fractures and dislocations, or both, of the vertebral bodies will be considered. Some of the less prominent changes are worth stressing. On the AP view, the line of the dorsal spinous processes should be followed carefully. Often, with a rotatory malalignment (as with a unilateral hooking of the facets) a characteristic deviation in this line at the point of dislocation will be found. Similarly, the distance between the spinous processes is noted on the lateral view; this is often widened at the site of a fracture-dislocation. The laryngeal air shadow should be identified since hemorrhage and edema may extend in front of the anterior longitudinal spinal ligament. A search for fractures of the laminae is particularly important. With significant displacement, these may pass in and press on the cord; or at the time of a posterior fusion, loose fragments may be driven inward in moving the neck into a slightly extended position.

Previous trauma or pre-existing osteoarthritic changes should be carefully considered and old films may be needed.

Doubts will often arise about the advisability of early laminectomy, and information on the existence of a manometric block may be needed. For this, a lumbar puncture is carried out and the manometric responses to unilateral and bilateral jugular, and abdominal compressions are determined.

In the past, it has been virtually impossible to carry out myelography. With the common lumbar technique, the patient must be tilted in the head-down position to run the radio-opaque dye into the cervical area. Counter-traction must be applied because of the neck injury and is exceedingly difficult to use in the head-down position. Further problems are noted in manipulating the head to hold the contrast material in the neck. These difficulties may be circumvented with the use of the lateral cervical puncture as used for percutaneous cordotomy.[2] With this approach, 1-2 ml of contrast material are placed in the upper cervical region with the head elevated and after skeletal traction has been applied with the patient on a Stryker or Foster frame. The dye is allowed to drop down to the area of a block or into the normal lordotic curve with the patient face-down. Portable X-ray equipment may be used.

Eight of these have been carried out in the last three years at Baltimore City Hospitals. On one occasion, an anterior disc exploration and fusion followed the finding of a moderate intact, disc protrusion with this limited type of myelographic examination. In the others, complete blocks occurred at the site of cord swelling. The films of one

patient are shown in Figure 2. The depictions were those of fusiform enlargements and were similar to the changes encountered with intramedullary cysts or tumors. In these, posterior explorations with laminectomies revealed only cord swelling and were not rewarding. It may be possible to use such films in the future so that this specific myelographic appearance will constitute one factor in rejecting laminectomy.





Fig. 2: Myelogram utilizing lateral cervical puncture. The lateral view (above) indicates a complete block between C_3 and C_4. A fusiform dilatation of the cord is indicated at the bottom of the AP view (right). These depictions are of primary cord swelling and are not indications for operative intervention.

Management in the Accident Room

Ambulance and Accident Room personnel must be educated very thoroughly in the handling of patients with serious spinal injury. Several aspects should be stressed including: the management of the litter, the use of boards, the application of a pulley device to the stretcher, and the use of many hands.

Opinions vary on the timing for tong application; most will be inserted following the development of cervical spine films. In certain instances, it is wise to insert the tongs quickly after admission and before the procurement of spine films. These cases include many patients with obvious neck injuries plus serious neurological defects. This plan is advantageous in that it provides early immobilization and reduction; it is dangerous in that unneeded applications may be made. In practice, such errors are made very rarely.

Varied tongs are available for skeletal traction. Such models as those of Vinke, Cone and others are used by many neurosurgeons and appear to be satisfactory. We have used the instrument modified from the original Crutchfield design.[3] The application is easy and the technique should be learned by all surgical house staff. An area above and behind the mastoid processes is shaved so that the points of the instrument may be applied in line with these bony tips and with the axis of the cervical spine. A drill with guarded points is directed at a right angle to the skull surface and is used to perforate the outer table of the skull at points marked with widely opened tongs. The tongs are inserted, tightened and then connected by a pulley to a weight of about 10-15 lb; the head is then elevated for counter-traction.

X-rays of the cervical spine are repeated in the Accident Room or in the Intensive Care Unit to fol-

low the alignment. In some cases, weights will be added with persisting dislocations and particularly when facets are hooked. There is no uniformity of opinion on the maximal weight which may be applied for these reductions and 60 lb or more have been used by some. An arbitrary limit of 34-40 lb is used in our service because of the fear of added damage to soft tissues from extensive traction. This weight may be applied for several hours and may be used in conjunction with muscle relaxants and with anesthesia before resorting to an operative procedure to relocate the facets.

Patients with severe neurological deficits are cared for on Stryker or Foster frames; other patients are nursed in bed. In both instances, appropriate traction and counter-traction are maintained. Circular beds are popular; however, in our experience these provide a greater opportunity for the patient to fall. In the accident room, attention will also be directed to tracheostomies which are needed with some high lesions, to shock which may be found from the loss of vasomotor control and from concomitant injuries and to bladder care.

Operative Interventions

As the initial procedures are being carried out, the indications for posterior or anterior bony decompressions will be considered in detail. In general, there are three groups: persistent dislocations, suspected cord compressions and open wounds.

Dislocations: If the normal alignment is not achieved after a reasonable period with skeletal traction and relaxants, the patient should be taken to the operating room for a posterior approach. It is useful to obtain a lateral cervical spine film before the anticipated procedure since anesthesia may reduce spasm and aid in the reduction. At operation, the laminae are exposed at the appropriate level and the hooked facet or facets are identified. A small portion of the obstructing edge of the lower facet is rongeured to allow the superior facet to slip down in its normal position. A posterior fusion is then carried out.

Cord Compression: Usually, the decisions for or against bony decompressions are not easily formed. There are, however, clear-cut indications in some settings. One is a suspicion of bony compression. Fractures of the laminae may be present and bony fragments may pass within; alternately, with vertical compression fractions, the anterior portion of a vertebral body may press inward on the cord. The progression in neurological findings is an indication for decompression as is, in some cases, the presence of unusual or unexplained findings. Pre-existing bony changes—those from Marie-Strümpell spondylitis or rheumatoid arthritis—should be considered since extradural hematomas may form when fracture-dislocations occur in conjunction with these states. As noted above, another indication is a myelographic block with a configuration suggestive of extrinsic pressure.

The finding of a manometric block with lumbar puncture may support the decision for operative intervention; it is, however, not a prime indication. Another minor indication for intervention is the need to expose the cord directly for impressions of transection, swelling and other changes and in general, to aid in formulating the prognosis.

There are also important reasons for not carrying out laminectomies, anterior decompressions or other procedures. One is the fact these procedures have not been clearly shown to offer beneficial decompressions. Secondly, the patient with acute cord injury is often in incipient shock from the loss of much of the sympathetic outflow and therefore not in ideal condition for operation. Thirdly, sizable hematomas and disc extrusions are extremely rare. Fourthly, the patients may be seen many hours after the time of injury and at the time when it is felt that the changes are irreversible. Finally and most importantly, it is unfortunately true that a few patients worsen after laminectomies or fusions. Accordingly, it seems reasonable to adopt a conservative attitude with reliance on skeletal traction and to use operative intervention only when clear-cut indications are present.

Arguments may be adduced for either the anterior or posterior approach if a decompression is decided upon. The choice will vary and will be based on factors other than the need for decompression. The posterior approach with a laminectomy is more popular since it offers more extensive exposure of the cord. The opportunity of removing broken laminar fragments is also present. The anterior approach is useful in that disc and bony protrusions usually lie anteriorly. It is a disadvantage in that the view of the cord and the decompression are limited even with the removal of a whole vertebral body.

Many variations may be found with the timing of fusions. With the anterior approach, a fusion with or without replacement of a vertebral body will be done at the time of exploration. A posterior fusion may be done at the time of an early laminectomy. Unfortunately, the operating time is then extended to a period of six hours or more at a time when the patient is in an acute phase. It is therefore better as a rule to carry out the posterior fusion electively a week or two later when the patient's condition has stabilized. A limited laminectomy may then be added for direct visualization of the cord in instances where early decompressions were rejected.

The use of tongs is perhaps the most useful therapeutic maneuver; however, this practice brings well-known hazards. The instrument will commonly pull out even with daily tightening and it will occasionally pass intracranially with the attendant danger of a brain abscess or other infection. It is therefore wise to remove the device soon after another form of support is provided. Typically, a posterior fusion is

carried out 10 to 21 days after injury; the traction is then lightened and the tongs are removed in another week or so. Sometimes, the tongs are removed very early as with some anterior fusions. A neck brace is sometimes substituted early, rather than late, with stable spines following relatively minor dislocations. At the other extreme, the patient may be left in skeletal traction for six weeks. This plan is rarely used at this time and is followed in unusual situations as with infection and extreme instability.

A Minerva plaster jacket is sometimes used rather than a bony fusion. This jacket unfortunately permits moderate muscle motion and in some cases it is better to substitute a halo which is fixed to the skull and to a plaster jacket.

Other measures may be employed in an attempt to treat cord swelling. Potent steroid derivatives are used by some in a manner similar to the common application for brain edema. The efficacy appears not to have been established. Local hypothermia of the cord is now being tested by a few groups who use irrigations of cool saline at the time of laminectomy. Again, this usage is similar to that of general hypothermia for head-injury victims in a previous era and similarly, the overall results are not clear.

Penetrating Injuries: Most of these are inflicted with missiles, knives or ice picks. It is particularly important to search for metallic fragments on X-ray films since the path may be traced. Nearly all of these are explored promptly for a debridement. The rare exceptions occur in instances where low-velocity injuries occur without direct involvement of the cord in the absence of gross contamination.

Two aspects involving public action should be stressed. One is the need for strong (yearly) efforts in education on potential dangers from water sports. This is particularly important in this locale because of the significant proportion of neck injuries from diving accidents. The other aspect is the initiation of public appeals for aid in rehabilitation and chronic care.

Summary

Some of the details of the diagnosis and the management of severe cervical spine injuries are noted. Emphasis is placed on conservative treatment with skeletal traction. The fact that the neurological status may deteriorate following either a laminectomy or a fusion is stressed and a list of indications for operative intervention is given. The use of limited myelography utilizing a lateral cervical puncture is described.

REFERENCES

1. Schneider, R. C., Cherry, G. L., and Pantek, H. E.: The syndrome of acute central cervical spinal cord injury. *J Neurosurg* **11**:546, 1954.
2. Mullan S., et al: Percutaneous interruption of spinal pain tracts by means of a strontium 90 needle. *J Neurosurg* **24**:921, 1963.
3. Crutchfield, W. G.: Further observations on the treatment of fracture-dislocations of the cervical spine with skeletal traction. *Surg Gynec Obstet* **63**:513, 1936.

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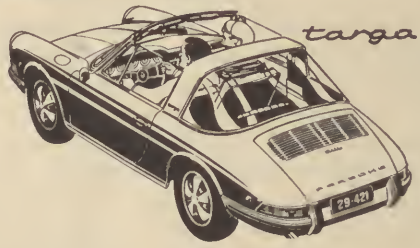
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Baltimore Nurses Exchange, Alice Weber 92
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Breon Laboratories 43
Bryman School 88
Burroughs Wellcome & Co., Inc. 104
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Cobb-Woods Services 73
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Herbert Cox—Correct Shoes 106
Deutsches Haus Restaurant 99
Dulaney Towson Nursing & Conv. Home 88
Eastern Overall, Rentex Div. .....2nd Cover
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Embassy Dairy 84
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Forty West Porsche-Audi 114
Franklin Uniform Co. 80
A. Gude Sons Co. 114
Hanna Rug Co. 82
Herget & Co. 18
Hidden Brook 29
Highland Hospital 74
House in the Pines Nursing Homes 70
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Koch Associates 85
Lederle Laboratories 2, 74, 103
Eli Lilly & Co. 4
Med-Chi Insurance Trust 107
Merck Sharp & Dohme 12-14
Metropolitan Washington Blood Banks, Inc. 92
Milton Inn 98
Monarch Lincoln Mercury 28
Murray Baumgartner Surg. Instr. Co., Inc. 100
National Drug Co. 7, 25-26
Parke, Davis & Co. 42, 75
Pielke Landscape Services 92
Wm. P. Poythress Co., Inc. 78
T. Rowe Price Growth Stock Fund, Inc. 106
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Roche Laboratories .....4th Cover
Manuel Schwartz Hearing Rehabilitation 92
G. D. Searle & Co. 40-41
Security Business Services, Inc. 113
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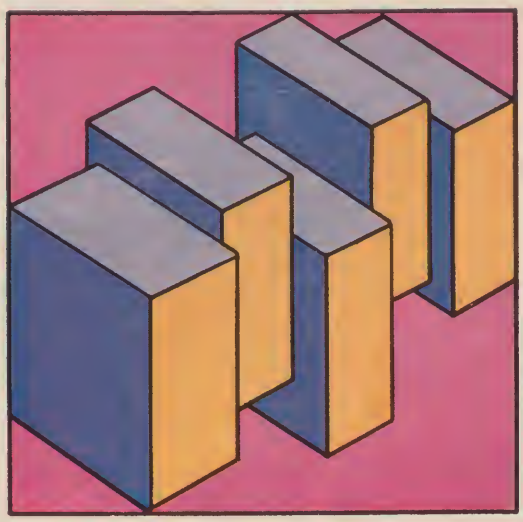
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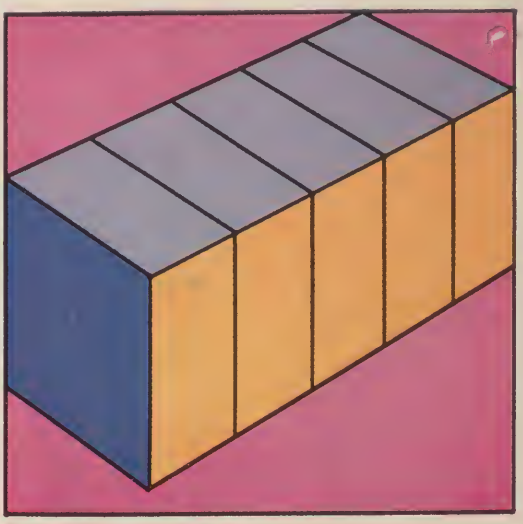
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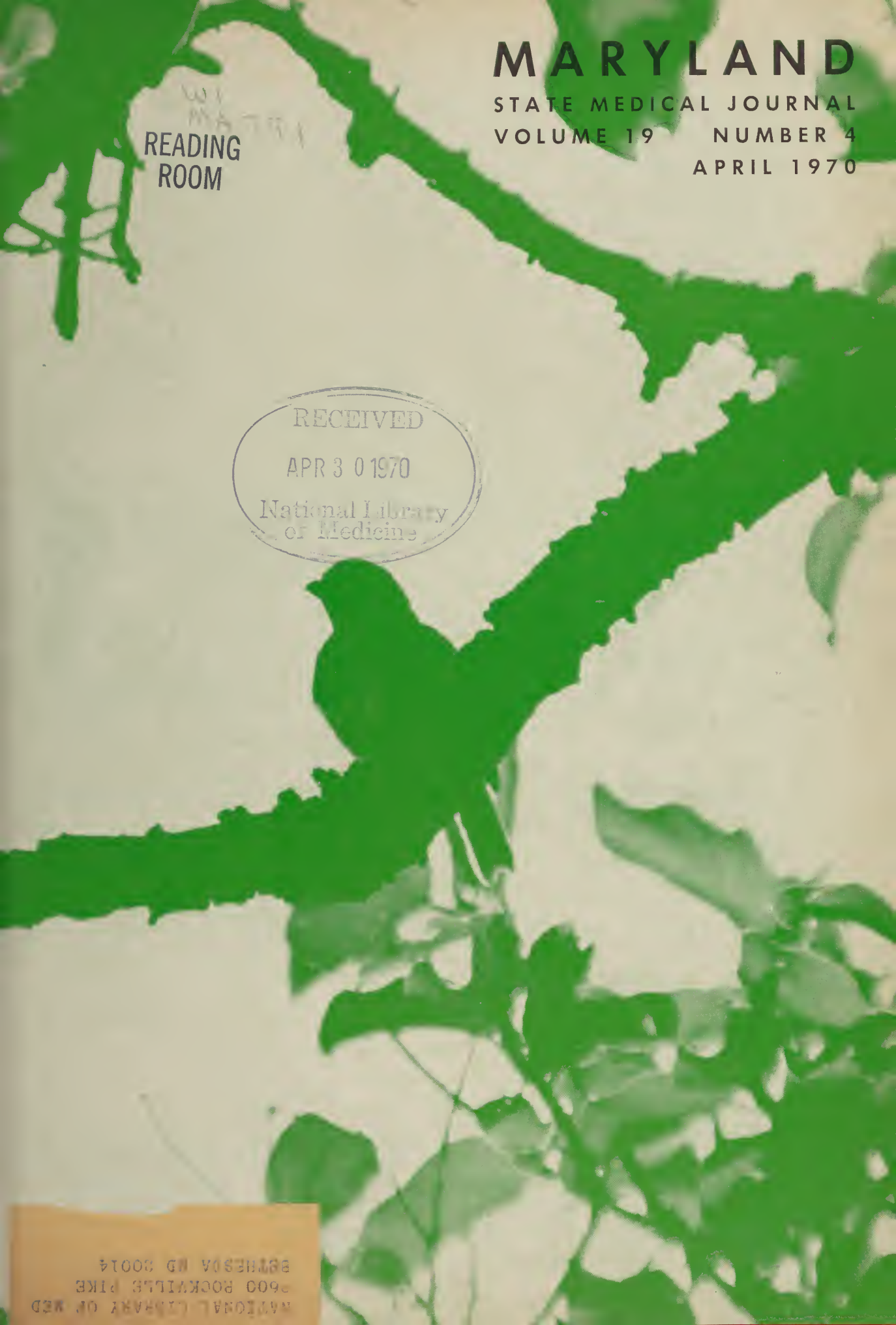
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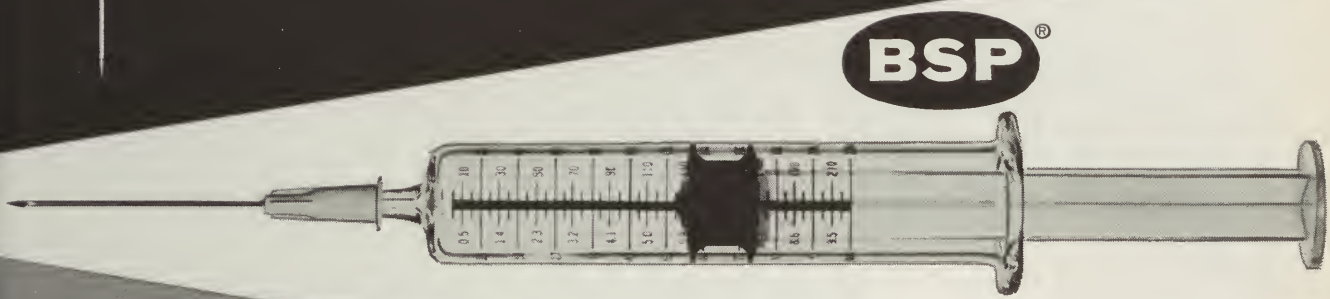
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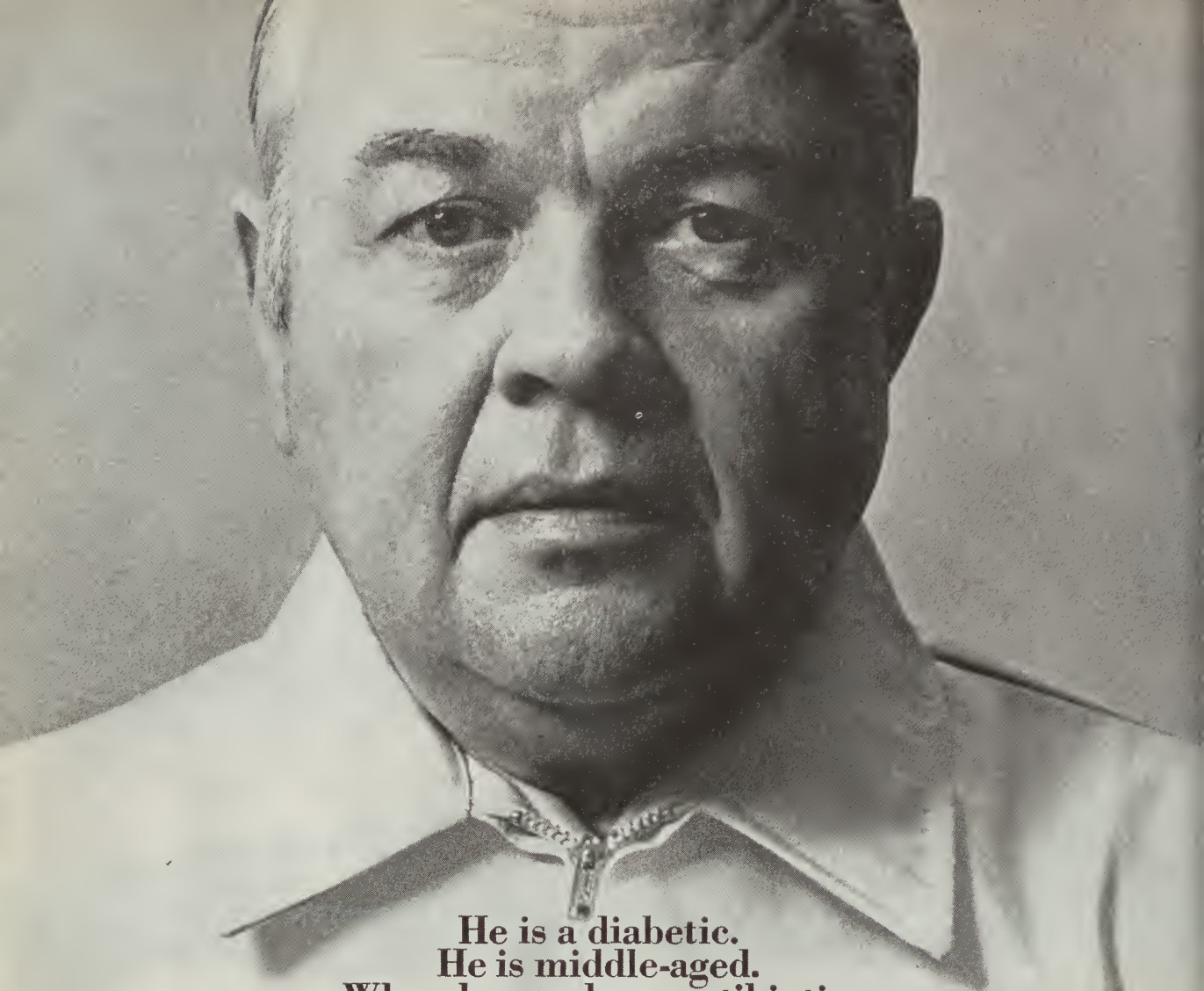
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CONTENTS:

Cancer Facilities in the Maryland Region, Louis P. Hellman, ScD .. 57

"Facilities for the diagnosis and treatment of the cancer patient are not equally available in hospitals in the Maryland region. This article reports on the availability of selected cancer services and facilities in the 37 hospitals surveyed, with suggestions for equalizing the availability of services to the cancer patient throughout the Maryland region."

The Cryostat Cone for Rapid Diagnosis in Carcinoma of the Uterine Cervix, Michael S. Baggish, MD; Daniel B. Kooyman, MD; J. Donald Woodruff, MD 64

"Expedient and accurate diagnosis has been the keystone of proper treatment in cases of carcinoma of the uterine cervix. Since, at present, 'conization biopsy' is most often used to determine the extent of the many lesions, such a method for rapid evaluation of the excised cervical tissue, with the primary aim being the elimination of diagnostic delays, is of great importance."

Post-Treatment Care of Patients With Pelvic Malignancy, Umberto VillaSanta, MD, FACOG 69

"Due to the need for costly equipment and specialized personnel, more women with pelvic tumors are referred to and treated in fewer medical centers which are recognized for their superior ability in handling this disease. The following presentation will attempt to synthesize the 40 years experience in the Gynecological Oncological Clinic at the University of Maryland School of Medicine."

Medicare and Nursing Homes: The Changing Scene, Leon Bernstein, PhD 73

"This paper reviews some of the more pressing problem areas affecting medical care of the aged, especially medical care in long-term facilities. These issues have special relevance to the Medicare program and particular interest for professionals who are actlve in the skilled nursing home field."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 77

Tuberculosis—Tuberculous Peritonitis 87

Maryland State Department of Health—Local Diagnostic and Advisory Services for Handicapped Children 89

Maryland State Department of Mental Hygiene—Employee-Patient Ratios .. 91

Alcoholism—The Pharmacological Approach to Alcoholism—Part 1, Stanley E. Gitlow, MD 93

Heart Page—Cardiac Irritability Secondary to Sympathetic Overactivity, Richard D. Biggs, Jr., MD; Richard P. Wenzel, MD 97

Baltimore City Health Department—Health Highlights of 1970 99

Pathology Page—Cytomegalovirus and the Post-Transfusion Syndrome, Robert L. Cavenaugh, MD 103

Rehabilitation Notes—Spinal Cord Injury: Psychiatric Considerations, Norman J. Knorr, MD; John C. Bull, Jr., MD 105

Library—Staff News and Review 111

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Doctors Take Note 5

Executive Secretary's Newsletter 9

Book Reviews 26

Woman's Auxiliary 31

MEDIC 32

The Month in Washington 34

Medical News 37

Orient Tour 42

Component Society News 47

Letter to the Editor 49

The Board of Medical Examiners 53

Membership Directory Errata 79

Information for Authors 114

Advertising Index 111

Classified Advertising 112


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APRIL 20-21, 1970
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International Symposium on Fetal Biochemistry and Physiology: Detroit, Michigan. The symposium will provide an intensive review of physiological and biochemical changes during intrauterine development. Contact: A. Alberto Hodari, MD, Director of Medical Education and Research, Crittenton Hospital, 1554 Tuxedo Ave., Detroit, Mich. 48206.

APRIL 23, 1970
MARYLAND SOCIETY FOR THE RHEUMATIC DISEASES

Meeting: Osler Hall, 1211 Cathedral St., Baltimore. Speaker: Norman Talal, MD, Senior Investigator of the Arthritis and Rheumatism Branch of the N.I.A.M.D. Dr. Talal will speak on "Auto-Immunity and Immune Tolerance in Clinical and Experimental S.L.E."

APRIL 23, 1970
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APRIL 23-25, 1970
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APRIL 25-27, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS/UNIVERSITY OF CALIFORNIA SCHOOL OF MEDICINE

Course—Sex in Society: Santa Rosa, California. Contact: University of California School of Medicine, Mendocino State Hospital, Box X, Talmage, Calif. 95481.

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APRIL 28, 1970
JOINT ANESTHESIA STUDY COMMITTEE/BALTIMORE CITY MEDICAL SOCIETY/BALTIMORE CITY HEALTH DEPARTMENT

Meeting: 7:30 PM, Osler Hall, 1211 Cathedral St., Baltimore. Speaker: Jay Jacoby, MD, PhD, Professor and Chairman, Department of Anesthesiology, Jefferson Medical College, Philadelphia, Pennsylvania. Subject: Anesthesia for Radical Surgery of the Head and Neck (lecture and case report). For information, contact: Calbert T. Seebert, MD, Department of Anesthesiology, University of Maryland Hospital, Baltimore, Md. 21201.

APRIL 28, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Surgical Treatment of Hypertension: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. 21201. Speaker: C. Thomas Flotte, MD.

APRIL 30-MAY 1-2, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Annual Spring Symposium—Gynecology and Obstetrics: Oklahoma City, Oklahoma. Contact: University of Oklahoma Medical Center, 800 NE 13th St., Oklahoma City, Okla. 73104.

MAY 2-3, 1970
TRI-COUNTY OB-GYN SOCIETY, SANTA BARBARA

Gynecological Urology Seminar: Santa Barbara, California. Contact: Jack R. Robertson, MD, 1430 East Main Street, Santa Maria, Calif. 93454.

MAY 4-5, 1970
AMERICAN CANCER SOCIETY, NEVADA DIVISION

12th Annual Cancer Seminar: Frontier Hotel, Las Vegas, Nevada. The seminar will emphasize round-table discussions of faculty with participants. The physician registration fee is $25. Write: The American Cancer Society-Nevada Division, 301 S. Highland Dr., Las Vegas, Nevada 89106.

MAY 4-9, 1970
AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

Steroid Chemistry—Gas Chromatography: Wichita, Kansas. Contact: American Society of Clinical Pathologists, Committee on Continuing Education, 710 S. Wolcott Ave., Chicago, Ill. 60612.

MAY 4-29, 1970
SPECIAL TRAINING DIVISION, OAK RIDGE ASSOCIATED UNIVERSITIES

Courses—Medical Radioisotopes, Nuclear Medical Technology: Oak Ridge, Tennessee. These courses are conducted by the Division for the U.S. Atomic Energy Commission. For additional information and applications, write: Special Training Division, Oak Ridge Associated Universities, P.O. Box 117, Oak Ridge, Tennessee 37830.

(Continued on page 18)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

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So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



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Tidewater Inn, Easton, Md. (TA 2-1553)

executive secretary's newsletter

April, 1970

MORE ON MALPRACTICE INSURANCE

While physicians in Maryland are experiencing increases in premiums for professional liability insurance, physicians in other states are faced with much higher increases.

For example, for $100,000-$300,000 coverage, physicians have to pay:

	California	Connecticut	Maryland ***
Class I	$ 573	$ 251	$ 96
Class II	$ 912	$ 440	$168
Class III	$1,658	$1,270	$287
Class IV	$2,106	$1,588	$383
Class V	$3,452	$1,588	$479

*** Maryland Rates through the Faculty's program only.

Meanwhile, attempts are being made to set up an Arbitration panel, as suggested by the Maryland Secretary of Health and Mental Hygiene, for the purpose of evaluating claims. This proposal, along with alternatives, is under discussion in the Faculty's Medical Economics Committee.

MEDICARE AND MEDICAID

The lack of newspapers in the metropolitan Baltimore area has created an information gap on the local as well as national level. Because of this, Baltimore-area physicians are missing all of the action on the current Medicare and Medicaid Report to the U.S. Senate Committee on Finance.

While there is much heat, but little fire to the report, it has received national headlines for its accusation that physicians are to be blamed for the soaring costs of the programs. The report received a large amount of publicity while the subsequent statements made by the American Medical Association and the National Medical Association were somewhat buried.

MEDICARE AND MEDICAID (cont'd)

The report takes issue with the various interpretations of the law by the Social Security Administration; and makes recommendations for "cost limitations". One of the cost limitations would be the establishment of set fee schedules for physicians. Another involves abolishing payments to physicians acting in a "supervisory" capacity in teaching hospitals.

The report also attacks Medicaid payments of "reasonable costs" to hospitals because they are based on the same scale as costs for Medicare, and recommends renegotiation of various payments made to institutions.

It is interesting to note that only 11% of the total costs of both Medicare and Medicaid are reimbursements to physicians while the bulk of the report is aimed at criticism of the profession. The report states, "the key to making the present system workable and acceptable is the physician and his medical society." Another comment refers to the prohibition against expansion of the system to cover more individuals and provide more benefits because of escalating costs.

FIRST AID ROOM ACTIVITY

The Faculty-sponsored First Aid Room in Annapolis was first opened for the 1963 session of the General Assembly. During that session, 101 patients were seen. Through February 24 of the current 1970 session, over 200 patients have been seen and treated.

JCAH SURVEYS

The Joint Commission on Accreditation of Hospitals is planning surveys of the following Maryland facilities in the next few months. A request has been received by the Faculty for any specific area of activity or involvement in which there is a problem situation or condition. If you have such information please contact the Faculty office.

Veterans Administration
Washington Sanitarium
Anne Arundel General
Eastern Shore State
Peninsula General
Deer's Head State
Crownsville State
Springfield State
Baltimore County General
Sheppard and Enoch Pratt
Prince George's General
Clifton T. Perkins State
Brook Lane Psychiatric
Eugene Leland Memorial
Garrett County Memorial
GBMC
Sinai
Suburban
U.S.P.H.S.
Bon Secours
U.S. Naval
Good Samaritan

John Sergeant
Executive Secretary

BUSINESSWISE

DOCTOR

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IN

INDIVIDUAL PRACTICE
PARTNERSHIP
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OR

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AND
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AND "KNOW HOW"
ARE AT YOUR ELBOW

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DIAL 752-5920

Professional Management Co.

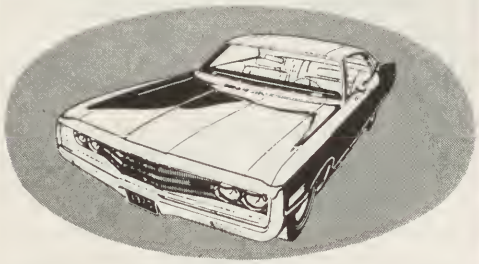
914 Aurora Federal Building
Baltimore, Md. 21201

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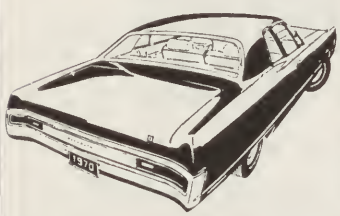
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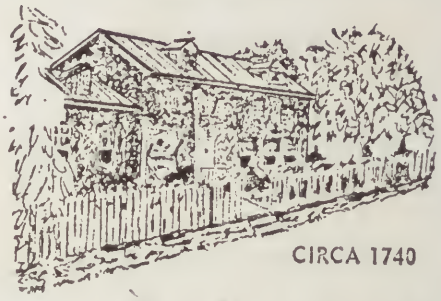
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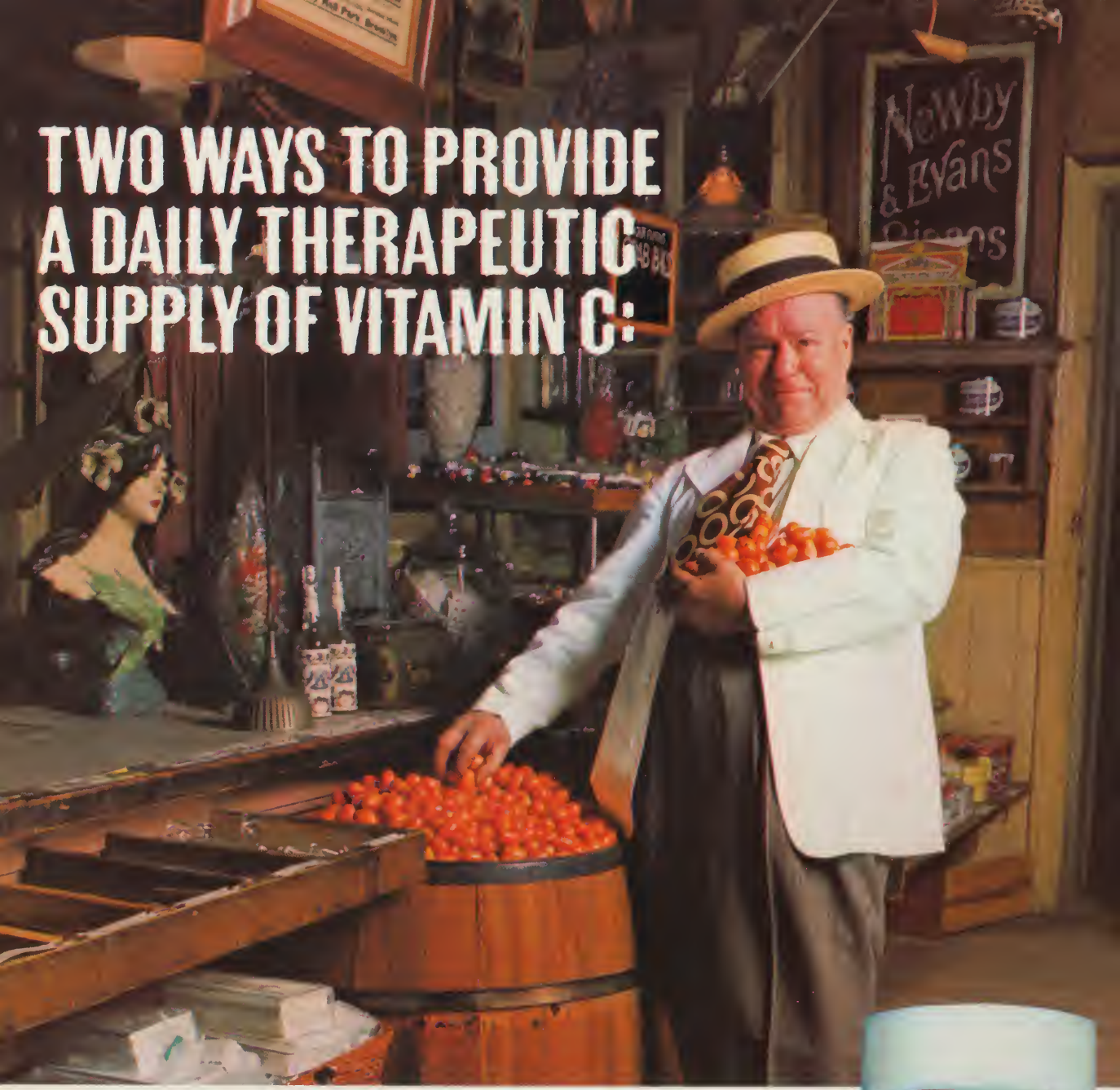
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Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

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Doctors Take Note . . .

(Continued from page 6)

MAY 6-8, 1970

AMERICAN COLLEGE OF PHYSICIANS

A Workshop-Type Symposium on Medical Intensive Care: University of British Columbia, Vancouver, B.C., Canada. Director: Dwight I. Peretz, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 7-8, 1970

COUNCIL ON VOLUNTARY HEALTH AGENCIES, AMERICAN MEDICAL ASSOCIATION

3rd National Voluntary Health Conference: Statler-Hilton Hotel, Washington, D.C. Conference theme: Health Team Relationships—Professional Associations, Governmental Agencies, and Voluntary Organizations. Write: 3rd National Voluntary Health Conference, Department of Health Education, Communications Division, American Medical Association, 535 North Dearborn Street, Chicago, Ill. 60610.

MAY 9-10, 1970

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course—Recent Advances in Obstetrics and Gynecology: Montreal, Canada. Chairman: R. M. H. Power, Jr., MD. Contact: The Secretary, Postgraduate Board, Royal Victoria Hospital, Montreal 112, Quebec, Canada.

MAY 10-13, 1970

AMERICAN ASSOCIATION OF PLASTIC SURGEONS

49th Annual Meeting: Broadmoor Hotel, Colorado Springs, Colorado. Program Committee Chairman: Erle E. Peacock, Jr., Department of Surgery, University of Arizona College of Medicine, Tucson, Arizona.

MAY 11-15, 1970

AMERICAN HEART ASSOCIATION

5 Days of Cardiology—Cardiology Today: Grady Memorial Hospital Auditorium, Atlanta, Georgia. Contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Md. 21201.

MAY 13-16, 1970

CHICAGO COMMITTEE ON TRAUMA, THE AMERICAN COLLEGE OF SURGEONS

Postgraduate Course—Fractures and Other Trauma: John B. Murphy Auditorium, 50 East Erie Street, Chicago, Illinois. The course, presented through a panel discussion, will include 41 faculty members covering orthopaedic, general surgical, neurosurgical, urologic, and plastic surgical subjects. Participants may receive 24½ elective hours of credit by the American Academy of General Practice. Fee: $100. To register, write: James P. Ahstrom, Jr., MD, Program Chairman, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

MAY 14-16, 1970

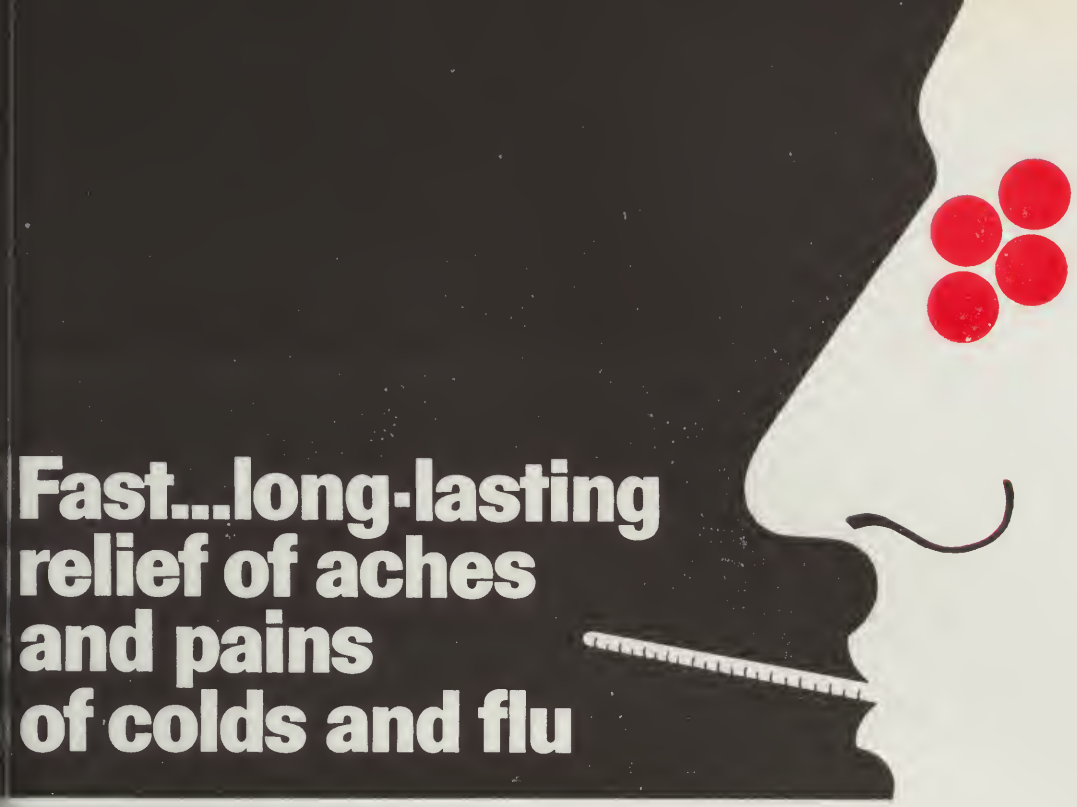
AMERICAN CANCER SOCIETY, MARYLAND DIVISION, INC.

9th Annual Seminar—Cancer of the Breast: Brown Palace Hotel, Denver, Colorado. Contact: Wendell P. Stampfli, MD, Director, Department of Radiology, St. Luke's Hospital, Denver, Colo.

MAY 26, 1970

JOINT ANESTHESIA STUDY COMMITTEE/BALTIMORE CITY MEDICAL SOCIETY/BALTIMORE CITY HEALTH DEPARTMENT

Meeting: 7:30 PM, 1211 Cathedral Street, Baltimore, Md. Speakers: Henry Lim, MD, Associate Professor of Anesthesiology, Assistant Professor of Obstetrics and Gynecology, Johns Hopkins University School of Medicine; John Tyson, MD, Assistant Professor of Obstetrics and Gynecology, Johns Hopkins University School of Medicine. Topic: Anesthesia for Obstetrics.



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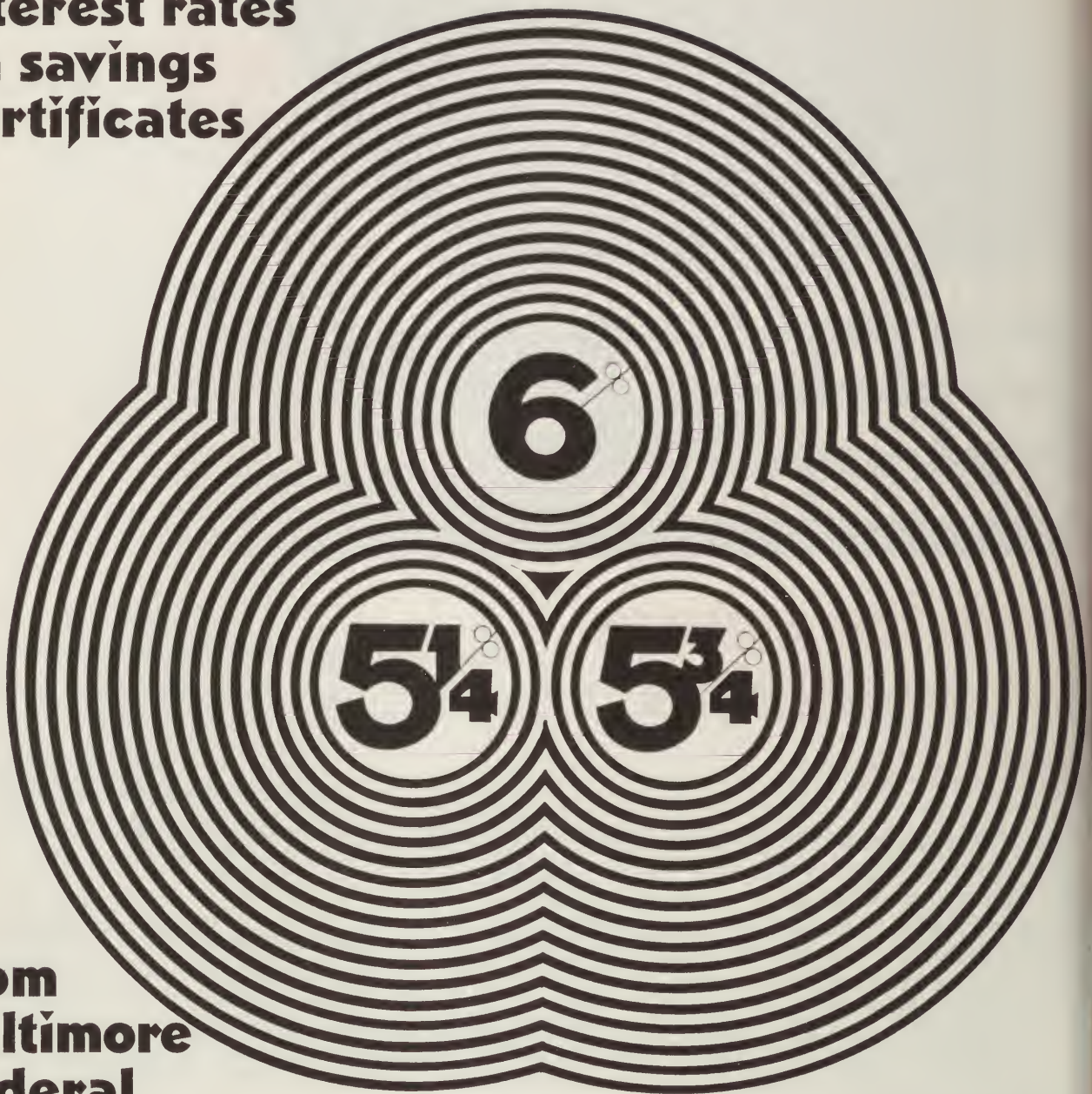
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Almost as good as castor oil.
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When ephedrine is too exciting or is contraindicated

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According to the Framingham Heart Study, the obese face:

86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*

Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

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Preludin®
phenmetrazine hydrochloride
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Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

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Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

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For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
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OPHTHALMOLOGY, Volume I, ed. Arnold I. Turtz, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This is another in a series of proceedings celebrating the Centennial of the Manhattan Eye, Ear, and Throat Hospital. Subjects covered during this event held in 1968 include: New Concepts in Ocular Therapy; Controversial Areas in Ocular Surgery; Pediatric Ophthalmologic Problems; Ophthalmic Plastic Surgery; New Techniques in Ophthalmology; and Complications in Ocular Surgery. The list of participants is worldwide and includes individuals from Maryland. While this publication presents a great deal of information for the already informed reader, it is also worth reading from the standpoint of gaining the latest knowledge in techniques and procedures that are available to patients suffering from eye disorders.

TEXTBOOK OF NUCLEAR MEDICINE TECHNOLOGY, Paul J. Early, BS, Muhammad Abel Razzak, MD, and Bruce Sodee, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This book is the result of a search for an applicable text for the training of nuclear medicine technologists. It has been divided into two portions: Nuclear Science and Clinical Theory. The clinical section uses a system rather than the usual organ approach, in an attempt to better correlate all body functions.

Because both sections represent the work of many authors compiled over a long period of time, no attempt has been made to document statements with precise references. However, a list of references will be found immediately following each section.

The content has been simplified as much as possible to make highly theoretical principles more easily understood.

PRACTICAL UROLOGY, Chester C. Winter, MD; The C. V. Mosby Company, St. Louis, Missouri 1969.

This volume is a concise accumulation of practical information on the subject, and is geared for use by medical students, general practitioners and surgeons; it is specially designed to present current concepts useful to the urologic specialist. Newer subjects such as renal transplantation, vesicoureteral reflex, renal hypertension, and radioisotope methodology in diagnostic urology are fully discussed. The conclusion of each chapter presents questions designed for the reader to test himself on the more important points developed within that chapter. This is a well organized book and one well worth adding to any medical library.

OTOLARYNGOLOGY, Volume II, ed. William F. Robbett, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This second volume is devoted to the proceedings of the Centennial Symposium sponsored by the Board of Directors of the Manhattan Eye, Ear, and Throat Hospital. It contains papers by international leaders in the field who presented talks on the tremendous changes that have occurred in the fields of ophthalmology, otolaryngology and plastic surgery in recent years.

The concepts of diagnosis and therapy given by the participants in this program reflect the best thinking on these topics today. The fact that they may have been controversial only led to their deliberate selection. This book is an excellent one for the individual who wishes to add to his knowledge the latest developments in these fields.

CARDIOVASCULAR SURGERY, CURRENT PRACTICE, Thomas H. Burford, MD, and Thomas B. Ferguson, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

Lord Brock, MS, FRCS, FACS, has written the foreword to this publication, and a formidable foreword it is. The authors have acknowledged their gratitude to him for writing such an outstanding work. In the foreword, Dr. Brock traces the history of the various forms of cardiovascular surgery and forecasts the needs for the future.

This book is a must for every person who has any interest in this subject. It is well written, clearly enunciating the various surgical procedures that have been employed to replace various portions of the heart, to correct existing anomalies, and to replace the heart itself. It is an excellent book, and one that should be read by almost every physician.

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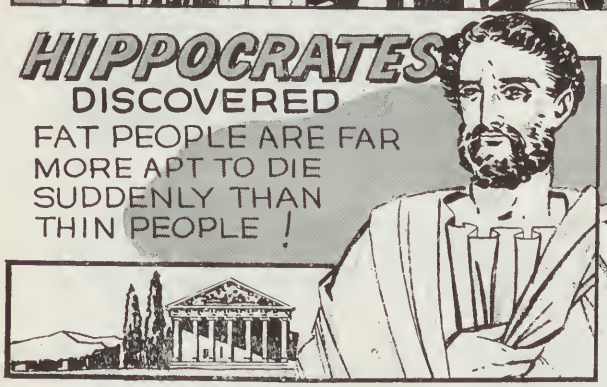
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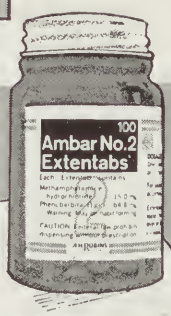
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Auxiliary Members Present Skit At Board Meeting

At the board meeting held at the Faculty building on November 3, 1969, eight Auxiliary members participated in a skit which illustrated the mechanics needed if a component Auxiliary wanted to present a package program. "Package Programs" were developed by the national Auxiliary to help focus public attention on current health needs, and to assist state and county Auxiliaries in planning and implementing programs related to these specific needs as part of their community health activities.

Under the direction of Mrs. Wallace H. Sadowsky, president, and with a script written by Mrs. Herbert J. Ulrich, regional vice-president of the national Auxiliary, the ladies presented the package program on Alcoholism, which included the showing of the film "A New Look at the Old Sauce". This film strip, purchased by the Auxiliary from the Texas Commission on Alcoholism, gives a crisp, colorful account of the alcohol story in 20 minutes. Designed especially for students and special-interest groups, the film does not present an in-depth look at alcoholism; its purpose, rather, is to stimulate viewer response through light coverage of selected topics. "A New Look at the Old Sauce" entertains as it informs; its purchase by the state Auxiliary makes it readily available for use by the component Auxiliaries in local communities in conjunction with the package program on Alcoholism. The package program on Alcoholism deals with the use—and abuse—of alcohol in today's society and the necessity for adequate alcohol education and alcoholism treatment programs. It contains a procedure guide, a fact sheet, a question-and-answer sheet for distribution to the audience, a source list of recommended films, an authoritative speech which can be presented by the program moderator, pamphlets concerning the symptoms, characteristics, and treatment of alcoholism, and a tally sheet to be filled in and mailed to national headquarters after the program has been presented by the Auxiliary.

Members of the cast were: Frieda Folk, Jone Berger, Marge Garey, Marge Lesch, Peggy Phillips, Ruth Palmer, Margaret Yow, portraying various officers of a county Auxiliary Executive Board; and Arlene Baybutt, as the physician who spoke on "Identifying the Alcoholic".

Other package programs available and on file at the Faculty building are Drug Abuse, Health Careers, Homemaker Service, Immunization, Mental Health of Children, Sex Education, Teenage Venereal Disease, The Block Mother Plan, Youth Health and Fitness, and Smoking.

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MEDIC
1970 SCHEDULE

APRIL 24, 1970 — 12:30 PM

TUBERCULOSIS AND ATYPICAL MYCOBACTERIA

Edmund G. Beacham, MD
Chief, Tuberculosis Division
Baltimore City Hospitals
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Discussion will be centered on clinical aspects of pulmonary tuberculosis including disease caused by atypical mycobacteria. Comments will cover tuberculin tests, differential diagnosis, and drug treatment.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:		
	Monday, April 27, 1970	12:30 PM
	Wednesday, April 29, 1970	9:00 AM
		2:00 PM

MAY 1, 1970 — 12:30 PM

HIATAL HERNIA

Vernon Smith, MD
Chief of Medicine
Mercy Hospital

The discussion will deal mainly with symptomatic sliding esophageal hiatus hernia and associated esophagitis. Practical aspects of diagnosis and management will be developed from known pathologic mechanisms. Special attention will be directed toward a critical review of various operations advocated for treatment of hiatal hernia, and toward the rational selection of patients for operation.

Sponsor: SACRED HEART HOSPITAL

Replays:		
	Monday, May 4, 1970	12:30 PM
	Wednesday, May 6, 1970	9:00 AM
		2:00 PM

MAY 8, 1970 — 12:30 PM

GRAND ROUNDS

Thaddeus Prout, MD
Chief of Medicine
Greater Baltimore Medical Center
Associate Professor of Medicine
The Johns Hopkins University School of Medicine

Several interesting cases illustrating some of the problems for diagnosis and therapy that have been observed will be discussed.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:		
	Monday, May 11, 1970	12:30 PM
	Wednesday, May 13, 1970	9:00 AM
		2:00 PM

MAY 15, 1970 — 12:30 PM

HEMOPTYSIS

Kenneth Lewis, MD
Chief, Cardiovascular Division
Baltimore City Hospitals

Richard Slavin, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Hemoptysis may be caused by primary disease of the lung, or diseases that produce secondary pulmonary changes. The clinical and pathological features of a patient presenting with hemoptysis will be discussed.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, May 18, 1970	12:30 PM
	Wednesday, May 29, 1970	9:00 AM
		2:00 PM

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

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(See page 52 for a list of participating hospitals and the standard weekly program schedule)

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THE MONTH IN WASHINGTON

The Senate Finance Committee approved a staff report on medicare and medicaid which was critical of both physicians and the administration of the health care programs. It included a recommendation for fee schedules for physicians' services.

In a joint statement, the presidents of the American Medical Association and the National Medical Association pledged support of their organizations to the committee's efforts to correct deficiencies and abuses in the two programs. However, the two spokesmen for organized medicine said "it would be tragic if . . . regulations were adopted whose effect would be to deny a greatly improved level of health care to the ghettos."

The AMA-NMA statement said that "we were greatly encouraged by the committee's comment that it 'believes that the majority of physicians, for whom information was requested with respect to medicare and medicaid as presently structured, have dealt fairly with these federal programs and with the federal government.'"

In regard to abuses and fraud, the statement said:

"Where these abuses exist, they must be rooted out. Both the AMA and the NMA are prepared to take very vigorous action within their power to help the committee and the government accomplish this."

It was noted that the committee had denied an AMA request many months ago that it be given the names of physicians involved in the committee's investigation.

"Despite this," the statement said, the AMA and the NMA through their own resources have been able to identify a number of physicians grossing more than $25,000 in these programs. . . .

"In some instances, medical societies had already taken appropriate action against individual physicians where the evidence warranted. In other instances, however, the AMA and the NMA have found that many of the physicians presumably included in the committee's study are dedicated physicians working in isolation in slum and rural areas who are literally being overwhelmed by a tide of sick humanity. . . .

"We therefore believe it would be unfortunate if the committee's report leads the public to believe that medicare and medicaid are riddled with fraud or that the number of physicians abusing the programs is large. Such is not the case . . . ."

The report said that incomplete and partial listings indicated 4,300 individual practitioners plus an additional 900 physician groups each received at least $25,000 from medicare in 1968, including 68 who received $100,000 or more. The report also contained a long list of physicians by state receiving $25,000 or more from medicaid in 1968. None was named; listings were by code numbers.

"Hundreds of the payments profiles indicate that the physicians involved might be abusing the program," the report said. "For example, we found many general practitioners each paid $15,000, $20,000, or more for laboratory services. We found large payments being made for what appear to be inordinate numbers of injections. In many cases we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes.

"The staff believes that the majority of physicians on whom information was gathered provided medically necessary services for which they were entitled to charge and be reimbursed. On the other hand, medicare's payments structure did little to discourage—in fact, it encouraged—high fees, and thus may well have contributed to the very substantial payment totals to those same physicians."

Recently, the Social Security Administration reported that about 2,500 cases had been investigated for fraud or abuse during the first three- and one-half years of medicare. It was emphasized that this was only a minuscule fraction of the total medicare transactions. Social Security Commissioner Robert M. Ball said:

"Medicare pays about 30 million doctors' bills and 12 million bills from institutional providers of services each year. It is clear from our investigations that the number of attempts at fraud or

abuse is relatively very small."

About half of the cases investigated, he said, resulted from clerical errors, misunderstandings or honest mistakes by physicians and health services. Up to January 20, 1970, the SSA had referred the cases of 13 individuals and organizations to the Justice Department with recommendations for criminal prosecution for fraud. Two physicians have been convicted in U. S. district courts and indictments have been returned against another five physicians and one nonphysician. Another five cases had been referred with recommendations that civil proceedings be started for the return of illegally collected funds. Early this year, social security investigators also were preparing an additional 35 possible fraud cases for referral to the Justice Department.

The most common types of alleged violations reported include physicians and providers billing for services not rendered, excessive charges, alteration of bills, duplicate billing, misrepresentation of types of services or dates of services, unreported discounts, or kickbacks, and employee embezzlement, medicare officials said.

The report's recommendations were aimed at providing "bases for remedying the serious, costly, and pervasive problems" of the two programs and make them "work more efficiently and economically." However, it was conceded that physicians constitute the cardinal factor.

"The key to making the present system workable and acceptable is the physician and his medical society," the committee staff said. "We are persuaded that at this point in time neither the government nor its agents have the capacity to effectively audit medical practice to assure that a given physician functions responsibly in dealing with the publicly financed programs.

"While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action by organized medicine (and other health professions) is necessary to do what is required with respect to monitoring care provided, and charges made for the care. . . .

"However, procedures which involve peer review should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective—not paper and token."

Report recommendations include: • fee schedules for physicians' services; • generic prescribing of drugs; • "curb overutilization by requiring prior professional approval of elective procedures and expensive courses of treatment"; • require the patient to name a "primary physician" to end "costly 'doctor shopping' "; • require states to provide medicaid recipients with statements outlining payments made in their behalf; • modify present law "to make practicable reasonable cost-sharing payments by the medically indigent"; • prohibit independent collection and discount agencies from collecting medicaid or medicare due bills that providers have sold to them; • improve federal administration, and establish cooperative arrangements with and between states; • establish a medicaid fraud and abuse unit in HEW, and require states to establish similar units; • combine the medicare and medicaid advisory councils.

The American Medical Association urged changes in proposed federal regulations concerning fraud under the medicaid program.

"While we do not condone in any way any fraudulent conduct of physicians in Title XIX (medicaid) or in any professional activity, we do believe that physicians will consider the new requirements an unwarranted affront to their integrity in their participation in the program," Ernest B. Howard, MD, executive vice president of the AMA, said in a letter to John D. Twiname, acting administrator of the medicaid program.

One of the proposed regulations would require physicians to sign form statements certifying that their claims were correct and that they understood fraud could subject them to prosecution.

These statements, Dr. Howard said, would serve no useful purpose because physicians already know that false claims could lead to prosecution. On the other hand, the regulation would be "regarded as offensive by many physicians since it obviously impugns their integrity," the AMA letter said.

The other proposed regulation would require state agencies to promptly report suspected cases of fraud.

"It is obvious that serious prejudice may result to a physician where the suspicion of fraud is publicized," the AMA said. "Even when the fraud is not later established, irreparable harm to the reputation of the physician will still have resulted. . . . We believe it will be better procedure not to report each suspected case, but to include in the report only those situations where the case has been concluded and fraud has been established."

* * *

The Nixon Administration submitted a fiscal 1971 budget calling for federal expenditures of $20.6 billion from general revenues for health purposes, an increase of $1.8 billion over

current spending levels. Medicaid and medicare Part B (physicians' services) accounted for much of the increase.

The overall medicare budget, including Part A (hospitalization), increased by $1.2 billion to $8.8 billion. Estimated medicaid costs to the federal government rose from $2.6 billion to $3.1 billion. However, the Administration hopes to cut the medicaid budget by $235 million by getting Congress to approve elimination of federal aid for extended care in mental institutions and nursing homes.

The budget for the current 1970 fiscal year, ending next June 30, still had not been approved when the new budget was submitted. Congress upheld President Nixon's veto of the appropriations for the departments of labor and of health, education and welfare on the ground that it was inflationary. The main funds at issue were educational aid for the federally impacted areas. The Administration and Congressional leaders negotiated a compromise.

In the 1971 budget, the lid was kept on health research spending by holding the overall increase in funds requested for the National Institutes of Health to $48 million. Some of the institutes' programs were cut and others given only small increases. Cancer research was allotted the largest increase, $28 million, pushing the 1971 budget for the program to $202.3 million. Heart research and child health research were increased by $17 million each.

Increases totaling $15.4 million were asked for alcoholism and drug addiction programs.

The Food and Drug Administration budget was upped by 10%, from $81.3 million to $89.5 million. Of this hike, nearly $2 million would be used to check safety of food additives and $2.2 billion for research on cancer and birth defects in animals exposed to pesticides.

A boost of $12.4 million, to $57.4 million, was requested for health services research and development projects "directed primarily at containing the rate of increase of medical care costs and improving the availability and utilization of health care especially for low-income groups." The federal programs in this field include: the development of alternatives to long-term stays in hospitals; experiments with private insurance firms to develop additional policies to encourage out-of-hospital care; experiments with comprehensive prepayment plans; improvement of municipal hospital systems; and development of new types of health service manpower.

An increase of $25 million, to $320 million, was requested for health professions education and manpower training programs.

* * *

The pros and cons, with emphasis on the cons, of birth control pills were aired at a Senate subcommittee hearing.

Most of the physician witnesses at four days of hearings by the Senate Antimonopoly Subcommittee testified that not enough attention has been paid to side effects. They urged that both physicians and drug companies be more diligent in calling patients' attention to the possible dangers in taking oral contraceptives.

Some of the witnesses expressed strong concern or alarm as to side effects. Others defended the oral contraceptives.

Developments related to the hearings included: • the Food and Drug Administration revived its birth control advisory committee which last fall concluded that the benefits of oral contraceptives outweighed the possible dangers so heavily that they could be evaluated as "safe." Roy Hertz, MD, New York, N. Y., a critical witness before the subcommittee, was named temporary chairman; • in advising physicians about the new labeling, the new FDA commissioner, Charles C. Edwards, MD, urged that patients be given full information about potential adverse effects; • the American College of Obstetricians and Gynecologists said it "deplored inaccurate or sensational reports concerning the scientific data on these drugs." The pills were termed "accepted therapeutic methods"; • E. B. Howard, MD, executive vice president of AMA, in a televised interview, urged American women to be calm in the face of the wide publicity about side effects and follow their physicians' orders; • the AMA's Council on Drugs said: "Oral contraceptives should continue to be prescribed by physicians for patients who require this type of contraception. However, we urge patients be advised that there are certain risks involved—the slight risk of vascular damage and the theoretical risk of carcinoma."

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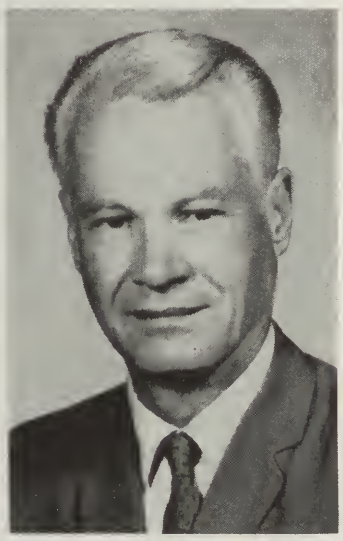
Maryland State Medical Journal
1211 Cathedral Street
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Att: Circulation Department

MEDICAL NEWS

Everard F. Cox, MD, has been appointed Chairman, Department of Surgery at St. Agnes Hospital.

In his new capacity, Dr. Cox is responsible for the medical administration of the Department of Surgery and for the maintenance of an approved surgical residency program which includes education and practice.

Dr. Cox has an extensive background in surgery. Among the positions he has held in Maryland are Assistant Professor of Oral Surgery, University of Maryland School of Dentistry; Assistant Professor of Surgery, University of Maryland School of Medicine; and Senior Surgeon with the National Cancer Institute in Bethesda.



Dr. Cox

* * *

Charles C. C. O'Morchoe, MD, associate professor of anatomy at the University of Maryland School of Medicine, has been awarded the PhD degree from the University of Dublin.

* * *

One of the Faculty's octogenarian members was recently honored for his fifty years of devoted health-care service in an unusual way—the members of his community erected two huge billboards alongside a highway which read: "Thank You Dr. Brumbaugh for Over 50 Years of Care."

Bruce Brumbaugh, MD, a member of the Howard County Medical Society, is a resident of Elkridge, and during his 50 years of practice has treated patients in Howard, Anne Arundel and Baltimore counties. He has delivered an estimated thousands of babies and has ushered three generations into the world. A firm believer in the all-encompassing role of the general practitioner, Dr. Brumbaugh says we need more GPs.

"My practice is my hobby," Dr. Brumbaugh told a newspaper reporter. "That's what makes it easier for me even though I have those long hours." (He works 60 hours a week.) "I'm going to work here until they put me under the sod."

* * *

The Department of Medicine at Sinai Hospital has named **Michael Levin, MD,** to head a new division of Infectious Diseases. This makes Sinai the first community hospital in the Baltimore area to establish such a specialty.

Dr. Levin received his MD degree from the University of Maryland and served as an assistant resident, then chief resident in medicine at Sinai. In 1969 he received a fellowship at the University of Maryland in infectious diseases.

Dr. Levin, an internist, is a member of the Baltimore City Medical Society.

* * *

Frederick H. Wilhelm, MD, has announced the removal of his office to 5807 Annapolis Road in Hyattsville for the practice of internal medicine.

* * *

May 15 is the deadline for submitting abstracts for the Scientific Program at the 1970 Annual Meeting of the American Society of Anesthesiologists, to be held in New York city at the Americana Hotel.

For further information contact: Evan L. Frederickson, MD, Chairman, Committee on Scientific Program, 961 Castle Falls Drive, N.E., Atlanta, Georgia 30329.

Information on scientific exhibits (deadline for applicants is also May 15) may be obtained from: Alon P. Winnie, MD, Division of Anesthesiology, Cook County Hospital, 1835 West Harrison Street, Chicago, Ill. 60612.

* * *

South Baltimore General Hospital has initiated a new "Hand Service" under the direction of Neil Novin, MD, Director of Surgery. Drs. Elliott Berg and Chris Tountas have worked closely with Dr. Novin on the project, which is believed to be one of the first in the nation.

As outlined by Dr. Novin, the purpose of the new service is to promote improved care for injuries, deformities and diseases of the hand, and to expand the knowledge of the house staff by providing close supervision and instruction.

* * *

A center for detection of birth defects in the unborn fetus early in pregnancy has been established at The Johns Hopkins Medical Institutions under the

auspices of the National Foundation-March of Dimes.

The Prenatal Birth Defects Prevention Center is designed to encourage couples to have children when they are reluctant because of the fear of having a defective baby.

The center uses amniocentesis, a relatively new technique for obtaining cells from the unborn child. Parents known to carry certain chromosomal disorders, such as Down's Syndrome, may be helped by the center. Also, families with sex-linked diseases, such as hemophilia and muscular dystrophy, could be helped.

Involved in the initial stages of development of the center were **Daniel Drachman, MD, Richard Heller, MD, Howard Jones, MD, and Robert Cooke, MD.**

* * *

Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, has announced that he has been assured of sufficient funds to provide rubella vaccination for all children in Maryland in the one-year through twelve-year age group. This group includes an estimated 930,000 children.

HEW Secretary Robert E. Finch intimated at a meeting in February that federal funds would be available for the program.

* * *

A uniform card for organ and tissue donation has been developed which is valid as a legal document under the provision of the Uniform Anatomical Gift Act, a model law formulated by the National Conference of Commissioners on Uniform State Laws.

The Uniform Act has met with considerable success. Forty states have adopted it.

One of the greatest advances embodied in the Uniform Anatomical Gift Act is the simplified procedure by which a gift may be made. In addition to a will, the Act provides that a donation by an individual can be made by any written document and that this "may be a card designed to be carried on the person". It must be signed by him and witnessed by two persons. The advantages of the card concept are particularly apparent in the emergency accident situation where time is frequently very limited, the prospective donor is unconscious, and the existence of a will is unknown.

The donor has three options: He may give any needed organs or parts; he may specify certain organs or parts; or he may give his body for anatomical study. The gift is not limited to a specific institution or a specific medical purpose. These latter provisions are a departure from traditional procedures, however, and a donor may specify a donee or place other limitations on his gift.

The form of the card was approved at a meeting on November 7, 1969, of the Ad Hoc Committee on Medical-Legal Problems of the National Academy of Sciences—National Research Council Committee on Tissue Transplantation.

Uniform donor cards may be obtained from the Faculty office or from the National Society for Medical Research, 1330 Massachusetts Ave., N.W., Washington, D.C. 20005.

* * *

Manuel Sanchez, MD, has been named the new employee medical advisor at The Johns Hopkins Medical Institutions.

Dr. Sanchez is a graduate of the University of New Mexico Medical School and served his internship at St. Johns Hospital in Tulsa, Oklahoma. He served his surgical residency at Bon Secours and St. Agnes hospitals.

Dr. Sanchez is board certified in general surgery.

* * *

Theodore E. Woodward, MD, head of the Department of Medicine, University of Maryland School of Medicine, has been elected president of the American Clinical and Climatological Association.

* * *

Recent appointments announced by the University of Maryland School of Medicine include: **Robert H. Armstrong, Jr., MD, John B. Hearn, MD, and James A. Lyon, Jr., MD, professors of radiology; Jerome Styrt, MD, associate clinical professor of psychiatry; Bernard S. Gordon, MD, and William N. Fitzpatrick, MD, clinical assistant professors of psychiatry; and Donald T. Lewers, MD, assistant professor of medicine.**

Daniel C. Wilkerson, MD, has been appointed instructor in anatomy.

* * *

William D. Tigertt, MD, professor of experimental medicine at the University of Maryland School of Medicine, has been named director of clinical laboratories at the hospital.

* * *

During the Annual Meeting of the American College of Obstetricians and Gynecologists, being held this month in New York city, **David R. Morales, MD,** of Baltimore, will be installed as a Fellow of the College.

* * *

According to the Ford Foundation Annual Report of 1969, The Johns Hopkins School of Hygiene and Public Health will receive continued support for its cooperative effort with the University of Lagos in research on population and family planning in the Lagos metropolitan area.

* * *

The Hearing and Speech Agency has elected its officers for 1970-1971. **Francis I. Catlin, MD, John M. Krager, MD,**

and Jimmie L. Rhyne, MD, were elected to the Board of Directors.

Cyrus L. Blanchard, MD, is medical advisor to the agency.

* * *

A. Earl Walker, MD, of The Johns Hopkins University School of Medicine, was designated as an American Medical Association representative at the Second Convention on Accident Prevention and Lifesaving held earlier this month in Edinburgh, Scotland.

The announcement was made by Ernest B. Howard, MD, Executive Vice-President of the AMA.

* * *

The twelfth guide in the series, "Guides to the Evaluation of Permanent Impairment" developed by the Committee on Rating of Mental and Physical Impairment, is now available. The new guide deals with the skin.

A limited number of copies are available without charge upon written request to the Committee, 535 North Dearborn Street, Chicago, Illinois 60610.

* * *

The first Alcoholism Medical Education Conference was held on the first of this month in New York city.

Frank A. Seixas, MD, Medical Director of the National Council on Alcoholism, in stating the reasons for holding such a conference, said: "This is the first time that the need for such a conference is compellingly clear, and it may be also the first time there is sufficient experience in faculties throughout the country to be able to present material of sufficient value to justify it.

During the conference, the education of nurses, social workers, alcoholism counselors and the utilization of Alcoholics Anonymous members as part of the alcoholism team were emphasized. The extent of student interest was also discussed.

Several medical schools now include alcoholism education in their curricula made possible through grants by the National Center for Prevention and Control of Alcoholism of the U.S. Department of HEW.

* * *

A bill authorizing 425 million dollars in federal funds to support training programs for family doctors and others in the field of family medicine was introduced in the U.S. Senate and House of Representatives simultaneously on February 9 by Sen. Ralph Yarborough (D-Tex) and Rep. Fred Rooney (D-Pa).

The bill, whose funds would be appropriated through 1975, provides for grants to be made by the Secretary of HEW to medical schools, teaching hospitals, and interns and residents who plan to make family medicine their specialty.

The proposed legislation was introduced on the first anniversary of the announcement of the approval of family medicine as a primary medical specialty. The specialty became a fact when the Council on Medical Education of the AMA and the Advisory Board for Medical Specialties approved a certifying board in family medicine.

The Yarborough-Rooney legislation is designed to assist medical schools and teaching hospitals to set up quality family practice departments and programs to produce highly-qualified family physicians as quickly as possible. The shortage of primary physicians has been widely recognized as a basic shortcoming in the American medical system.

The bill covers not only financing the operation of training programs, but also construction of facilities designed to make such programs functional. Also covered are training programs to produce heads of departments and teachers of family medicine. In addition, the bill incorporates a provision for training paramedical personnel to work in the field.

* * *

The cooperation of physicians is requested in the referral of patients with Ewing's Sarcoma for a continuing study being conducted by the Radiation Branch of the National Cancer Institute at the Clinical Center, National Institutes of Health in Bethesda.

Patients who have received no treatment are preferred, but selected patients with previous therapy will also be accepted for admission as inpatients.

Upon completion of their studies, patients will be returned to the care of the referring physician, who will receive a summary of findings.

Physicians interested in having their patients considered for admission to study may write or call: Ralph E. Johnson, MD, Clinical Center, Room B1B-41B, NIH, Bethesda, Md. 20014. (301) 496-5457.

* * *

The World Medical Association, organized to protect the professional interests of the medical profession and the cause of world peace, is offering a handsome certificate to each physician who applies for membership.

Upon receipt of the membership application, accompanied with a check for $10 in annual dues, the Association will send the 8½″ x 11″ certificate, bearing the member's name and the signature of the WMA secretary general. Members also receive a membership card, a subscription to *World Medical Journal* and copies of *News Items.*

Applications should be addressed to World Medical Association, Inc., (Dept. 535), 10 Columbus Circle, New York, 10019.

* * *

Ralph Weber, MD, has moved from his office at 1010 St. Paul Street to Lutheran Hospital, 730 Ashburton Street, Baltimore.

* * *

Two Maryland physicians have been granted Fellowship in the American College of Cardiology.

Admitted to the college's highest membership classification are: **John J. Curry, MD,** Silver Spring; and **Donald H. Dembo, MD,** Baltimore.

* * *

Two-month "Refresher Residencies" are being offered by the Peter Bent Brigham Hospital in Boston to six qualifying, selected, practicing Fellows of the American College of Surgeons for a year at the junior assistant resident level.

The position will carry the designation of graduate assistant in surgery. An estimated cost of $1,000 a month will be shared by the Fellow, the hospital, and the department of surgery.

* * *

"Prevention of Obsolescence in the Physician" is the title of the paper presented by Archie R. Cohen, MD, of Clear Spring, February 7 at the 66th Annual Congress on Medical Education in Chicago.

Dr. Cohen is a member of the Board of Medical Examiners.

* * *

The Social Security Administration withdrew certification from 23 extended care facilities during 1969 because they did not meet Medicare's quality standards, Robert M. Ball, Commissioner of Social Security announced earlier this year.

This brings the total to 56 extended care facilities whose participation in Medicare has been terminated since the post-hospital extended care part of the program began operation in January 1967.

Commissioner Ball also stated that in 1969, 460 extended care facilities voluntarily withdrew from participation in the program—some because it appeared they could not upgrade their care or facilities to meet the standards.

As of December 1, 1969, there were 4,850 facilities participating in the program.

Following initial certification, extended care facilities with no significant deficiencies are resurveyed every 18 months. Those in substantial compliance, but with correctible deficiencies are resurveyed more frequently until the necessary improvements are made.

* * *

The American College of Obstetricians and Gynecologists announced in its January Newsletter **that the college's Executive Board has confirmed the creation of a specialty division of pediatric and adolescent gynecology; the approval of the concept of a Registry of Human Intersexuality and provision of a limited support for the Registry on a matching basis; agreed to support the principles involved in legislation on family planning and population research.**

* * *

The American National Red Cross has recently issued a pamphlet entitled "The 20 Most Common Excuses for not Giving Blood" which along with a list of the excuses carefully explains why one should stop making these excuses and donate an hour and a life-saving pint at least once a year.

Copies of the pamphlet may be obtained by contacting: Blood Program, Eastern Area, American National Red Cross, 615 North St. Asaph Street, Alexandria, Va. 22314.

* * *

Theodore E. Woodward, MD, of Baltimore, has been named recipient of the 1970 James D. Bruce Memorial Award of the American College of Physicians for his distinguished contributions to preventive medicine.

Dr. Woodward is Professor and Chairman of the Department of Medicine at the University of Maryland School of Medicine.

* * *

The American Board of Obstetricians and Gynecologists has certified the following Baltimore physicians: John C. Norton, Jr., MD, Robert B. Giangrandi, MD, and Antonio Galindo, MD.

* * *

Drs. Ephraim T. Lisansky and W. Barry Wood, Jr., both of Baltimore, have been elevated to the position of Master of the American College of Physicians.

Dr. Lisansky is a member of this Journal's Editorial Board.

* * *

The International Commission on Radiation Units and Measurements (ICRU) is seeking nominations for the second award of the ICRU Gray Medal.

The Gray Medal award was established in 1967 for outstanding contributions in the scientific fields of interest to ICRU. It honors the late Louis Harold Gray, former member and Vice-Chairman of the commission.

For information, or to submit the name of a nominee, contact: W. R. Ney, Technical Secretary, ICRU, 4201 Connecticut Avenue, N.W., Washington, D.C. 20008.

* * *

According to the Health Insurance Institute, 2,415,000 Maryland citizens under 65 had private hospital expense insurance at the beginning of 1969. Surgical Expense insurance was issued to 2,148,000 persons under 65 at the same time; and 1,905,000 were covered with regular medical expense insurance, and 967,000 with major medical expense coverage.

Total health insurance benefits paid in the state by private health insurance organizations in 1967 were $168,267,000.

The latest available figures show that there were 3,433 physicians in private practice in the state in 1967; 1,743 dentists as of mid-1968; 2,242 registered practicing pharmacists at the beginning of 1969; and 9,840 employed professional nurses as of 1966.

* * *

The Women's Auxiliary of the American Electroencephalograpic Society will accept manuscripts until June 1, 1970 for the Annual Hans Berger Award.

One meritorious manuscript dealing with electroencephalography, either clinical or experimental, will be selected for the $300 award. Eligibility is limited to individuals at pre-doctoral (PhD or MD) and early post-doctoral levels. Candidates shall not be more than five years post-doctoral or two years post-residency.

The paper selected will be included as part of the Society's scheduled scientific program. Manuscripts should be sent to: Dr. Reginald G. Bickford, Program Chairman, Neurosciences Department, School of Medicine, University of California at San Diego, La Jolla, California 92037.

* * *

Richard B. Hornick, MD, director of the division of infectious diseases at the University of Maryland School of Medicine, participated in a symposium on typhoid fever conducted in January by the U.S. Naval Medical Research Unit No. 3 in Cairo, Egypt.

* * *

In his annual report, delivered to the Board of Trustees of South Baltimore General Hospital, **Robert T. Parker, MD,** Chief of Staff, announced that 30 physicians have been added to the hospital's visiting staff; the new Hand Surgery Service has been implemented; the scope of patient care has been expanded with the opening of the Minimal Care Unit; the patient load has increased in all areas; three summer training programs for medical students brought representatives from the University of California at Los Angeles, Emory University in Atlanta, the University of Maryland, and the Universities of Dublin, Edinburgh, and Copenhagen.

Four of the hospital's six American-educated interns elected to remain for additional training; and a temporary affiliation was established with the University of Maryland for pediatric residency training.

South Baltimore General Hospital entered the field of community postgraduate medical education with the Maryland Heart Association Symposium in September 1969.

Dr. Parker credited the hospital's continuing success to "the combined efforts of all—trustees, administration, nursing, paramedical personnel and a dedicated staff."

* * *

Assistant professor of surgery at the University of Maryland School of Medicine, **Robert M. Ollodart, MD,** has been named an American Heart Association investigator.

The association will support his research in transplantation and transplantation immunology for the next five years beginning this July.

* * *

James C. Allen, MD, associate professor of medicine at The Johns Hopkins University School of Medicine, has been appointed associate professor of medicine at the State University of Buffalo School of Medicine.

* * *

If any physician is in doubt that the American Medical Association is not his organization, he hasn't enjoyed exposure to the wide range of services performed for him, his patients and the public by the AMA headquarters staff in Chicago, at the corner of North Dearborn, State and West Grand Avenue.

Within the nine-story, block-long building are housed the day-to-day administrative, creative, and liaison staff—numbering almost 1,000 employees. The various divisions and departments represent the nerve center of American medicine, and their activities are open for each visiting physician to view.

The AMA's tour guide program during 1969 provided a staff of 14 young ladies to escort visitors throughout the building; these guides have other administrative duties, but volunteer as hostesses to all visitors during the year, including 45 medical students from Germany and another touring group of 50 young Scandinavians. Another large assignment was some 100 high school seniors in Project Wingspread, an organization to "open doors" to disadvantaged young people.

A tour of the AMA building was provided also to individual physicians and delegations from 16 foreign nations—Austria, Belgium, Brazil, Canada, England, France, Germany, India, Japan, Korea, Nigeria, Norway, Pakistan, the Philippines, South Africa and Viet Nam.

Special tours are now being planned to host the thousands of physicians and their families and guests who will be attending the AMA Annual Convention in Chicago, June 21-25.

* * *

New appointees to the Governor's Comprehensive Health Planning Advisory Council are **William M. Hart of Cambridge, and Edwin D. McGee of Pocomoke City.**

* * *

MED-CHI TOUR

The Medical and Chirurgical Faculty is sponsoring another exciting tour in the near future:

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Make your reservations NOW: For information and reservations contact Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles Street, Baltimore 21201 (301-727-0680) or Mrs. Genevieve Ritchie, the Faculty office, 1211 Cathedral Strect, Baltimore 21201 (301-539-0872).



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Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

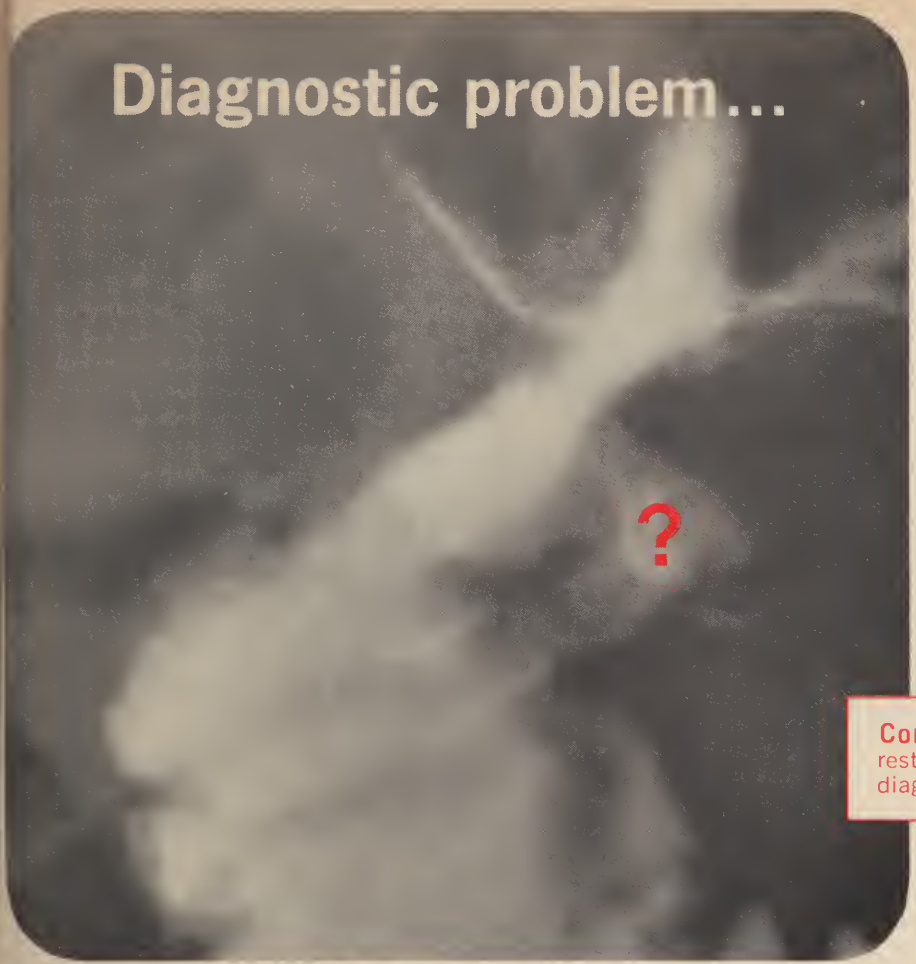
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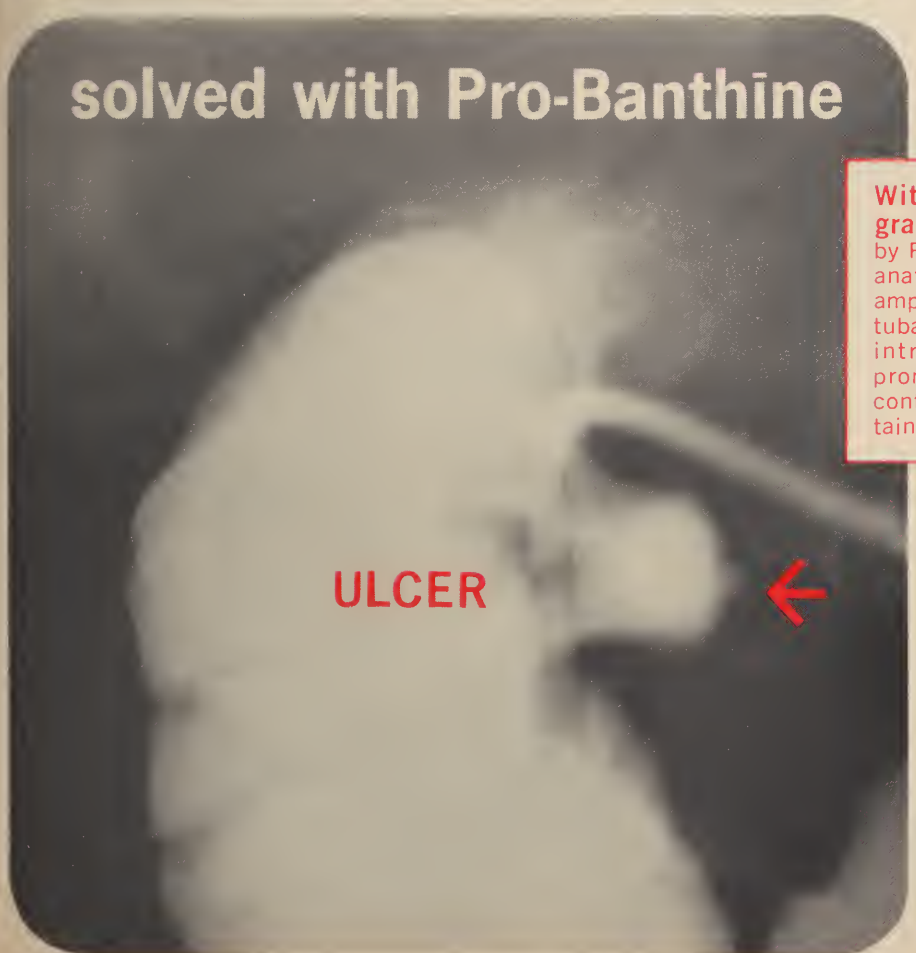
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Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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Baltimore County Medical Association

The February meeting of the Baltimore County Medical Association was called to order by the President, Wilmer Gallager, Jr., MD, at 1:30 PM on February 18, 1970, at the Greater Baltimore Medical Center. The President thanked T. E. Prout, MD, for the invitation to hold the meeting at the hospital.

Dr. Gallager welcomed Drs. Daniel Negrete and Alvin Wenger, two new members.

The minutes of the previous meeting were approved and Herbert Levickas, MD, the Secretary-Treasurer, reported a total of $21,894.43 in the treasury. Theodore Patterson, MD, reported that the Board of Governors met on January 21, 1970. Most of the meeting was devoted to a discussion of proposed bills which are being introduced into the 1970 Legislature. A dinner-meeting was held with the Baltimore County legislators in Annapolis. He feels that there was a good exchange of ideas.

The following applications were approved: Active —Syed Ali, MD, John Bryant, MD, and Charles Ryan, MD; Associate—Julia Novos, MD, and Douglas Puryear, III, MD; Affiliate—Elsa Merani, MD.

The President announced the untimely death of one of our members, Balbino Tayag, MD.

John Krager, MD, the Vice-President and Program Chairman, announced that the March meeting would be held at the Brentwood Inn and the April meeting at the Sheppard Pratt Hospital.

Dr. Levickas announced that the Association's annual dinner-dance will be held on April 11 at the Tail of the Fox.

The President then introduced Dr. Prout, of the Greater Baltimore Medical Center, who welcomed the members and then turned the meeting over to Alvin Wenger, MD, Head of the Department of Otolaryngology. Dr. Wenger presented the first paper on a "General Review of the Anatomy of the Ear". A film developed by the Department demonstrated the anatomy of the nose, using intranasal photography. The other speakers and topics were: Joseph Atkins, MD, Senior Resident, "Epistaxis"; Walter E. Loch, MD, "Sinusitis"; Harry P. Porter, MD, "External Otitis"; George C. Alderman, MD, "Serous Otitis"; Samuel Lumpkin, MD, "Foreign Bodies of the E.N.T."; Mr. Thomas Hagepanos, "The Audiogram"; and R. C. Chambers, MD, "Early Detection of Oral Carcinoma". A question and answer period followed.

Dr. Gallager thanked Dr. Wenger and the Department of Otolaryngology. There being no further business, the meeting was adjourned.



Dr. Theodore Patterson, Past-president of the Baltimore County Medical Association, presents an award on behalf of the Medical and Chirurgical Faculty to Mrs. Louise Couper of Dundalk, in Baltimore County, for her outstanding contribution to cancer patients and the Cancer Drive in Baltimore County.

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OPINION

Dear Sir:

The Medical and Chirurgical Faculty is chartered under the Maryland laws as a nonprofit organization to bring into one compact society the medical profession of the State of Maryland; to extend medical knowledge and advance medical science; to elevate the standards of medical education and secure the enactment of just laws relating to the practice of medicine and the public health; and, to foster friendly relations among physicians.

In compliance with Maryland laws and parliamentary procedure, equality of members is basic; and, all component society members as of right must have true representational equality.

The bylaws of all components cannot contravene the bylaws of the parent Med-Chi Faculty bylaws.

Under the bylaws of Med-Chi, April 1969, Article VI—House of Delegates, Section 5, subsection (c), page 15: One delegate from each chartered component society and one additional delegate for each 50 active members and Forty-year members or major fraction thereof.

Section 6, page 16 . . . Delegates and alternates shall serve for a term of one year or until their successors are elected.

We have a very questionable bylaw contradiction, under bylaws of Baltimore City Medical Society, March 1, 1968. Article V—Officers and Delegates, Section 8, page 7: As nearly as possible, one half of this Society's allotted delegates and alternates to the House of Delegates of the Medical and Chirurgical Faculty shall be nominated and elected each year by this Society in the same manner and at the same time as that provided for officers. They shall serve for a term of *two years* or until their successors are elected.

In other words, under Baltimore City Medical Society bylaws delegates and alternates, in compliance with State Society bylaws, should serve for a term of one year until their successors are elected; and, each City Society delegate (or alternate) at the House of Delegates is entitled to his vote during the year. Baltimore City Society doubles its delegate's terms through its probable contravention of Med-Chi bylaws. Is this true representational equality or fairness to the other components and to alternate replacements? If the 32 delegates are to represent Baltimore City Medical Society as proportionately indicated, they should be elected for one-year terms in compliance with the State Society bylaws.

The accompanying Table I showing the number of delegates allowed per number of members of each component society, indicates that our State Medical Society does not follow the one man-one vote principle of equal representation. At present each component is entitled to one delegate plus one additional delegate for each 50 active members and Forty-year members. Table I shows one delegate to each component; and, the fact that the majority of components do not have 50 members produces a startling disproportion of delegates to members. For example, take the total number of delegates apportioned to the total individual members of the larger components—those with membership of 100 or more. Here we find, as the accompanying Table II shows, 2,843 members representing approximately 84% of the entire membership of 3,372 have 65 delegate votes or 60% of the total number of delegates. This leaves 16% of the total membership of the State Society with 40% of the delegate votes.

TABLE I
COMPONENT MEDICAL SOCIETIES

	Number of Members	Number of Delegates
Allegany County	85	3
Anne Arundel County	127	4
Baltimore City	1555 active & 40-yr. members	33
Baltimore County	302	7
Calvert County	6	1
Caroline County	7	1
Carroll County	50	2
Cecil County	31	2
Charles County	12	1
Dorchester County	24	1
Frederick County	62	2
Garrett County	5	1
Harford County	56	2
Howard County	20	1
Kent County	14	1
Montgomery County	543	12
Prince George's County	251	6
Queen Anne's County	4	1
St. Mary's County	21	1
Somerset County	8	1
Talbot County	40	2
Washington County	102	3
Wicomico County	76	3
Worcester County	8	1
	3409	92

TABLE II
LARGER VS. SMALLER COMPONENTS

	Number of Members	Number of Delegates
Anne Arundel County	127	4
Baltimore County	302	7
Montgomery County	543	12
Prince George's County	251	6
Washington County	102	3
Baltimore County	1555	33
	2880	65

If we compare the number of delegates of the combined Baltimore city and Baltimore and Washington Metropolitan components to the number of remaining components, another disparity, as seen in Table III, becomes evident. Baltimore city and the Metropolitan areas of Baltimore and Washington have a combined membership of 2,761 or 82% of the entire membership, but are represented by only between 58% to 59% of the delegates. The remaining components, comprising only 18% of the total membership, are represented by 41% or 42% of the delegates.

TABLE III
BALTIMORE CITY AND BALTIMORE WASHINGTON METROPOLITAN AREAS vs. REMAINING COMPONENTS

	Number of Members	Number of Delegates
Baltimore City	1555	33
Anne Arundel County	127	4
Baltimore County	302	7
Howard County	20	1
Montgomery County	543	12
Prince George's County	251	6
	2798	63

Clearly, reapportionment is in order. We have ample precedent in constitutional and statutory law; and, in accepted parliamentary procedure, to ask for a change to the one man-one vote principle.

The U.S. Supreme Court has set a guide line by ordering reapportionment of the Maryland legislature in keeping with this principle. Our State Society can do and should do no less. We must examine whether our State Society is so apportioned that it does rightfully indeed give to component societies the number of delegates on the one man-one vote basis, as in the legislature. While the Supreme Court ruling may not be binding on us legally, it does provide us with a precedent for a rational and fair overhaul of our State Society's representative system. Is a physician, duly licensed by his peers, entitled to any less vote than that constitutionally granted any citizen of the U.S. in matters of voting?

Our Maryland State Corporation Law (Public General Laws—Article 23), on the other hand, appears to indicate that our defiance of the one man-one vote principle is illegal. Med-Chi is a non-stock corporation with each member the equivalent of a stockholder in a stock corporation. A perusal of Article 23 and its supporting case law is replete with reference to equal voting rights of stockholders (ie, the equivalence of society members), supporting the one man-one vote principle. For example, Art. 23, Sec. 39 is upheld in the case of First Mortgage Bond Homestead Assn. vs. Baker—157 Md. 309:—A stockholder is entitled to the opportunity to attend and be heard if he wishes and to vote on the measures provided at a corporate meeting. Because voting in Med-Chi is at present based on a representative system, we do not expect each member to vote. However, we do expect each member's vote of each component society to be equally represented. Can we truly say that we members of the Component Societies are given this representational equality under our present system?

Furthermore, there is ample precedent in the accepted guides for parliamentary procedure to provide us with an additional rational, as well as practical basis for the one man-one vote principle.

Robert's Rules of Order, revised 1951, states: "Equality of members is a fundamental principle of deliberative assemblies."

Lloyd E. Smith in his *A Manual of Parliamentary Law* states: "The fundamental principle underlying the relations of members to each other is EQUALITY."

Another inequity that must be rectified within the Society is the manner in which resolutions or motions may be introduced. In our state legislature and Baltimore city council, any citizen has the right through his representative to introduce a bill. Should any qualified member in good standing of our state or local society have less a right within his professional assembly? There is ample precedent within the accepted rules of parliamentary procedure and within the practice of legislative bodies in this State to bring about this change.

At present, in order for a State Society member to introduce a resolution directly to the Medical and Chirurgical Faculty, more than one signature is required. The bylaws state that a resolution introduced by an individual member must have the endorsement of either one third of the membership of his Component Society or 30 members, whichever is smaller. For example, introduction of a resolution in Baltimore City Medical Society requires 30 signatures or 30% of its 1,555 voting members, while only 30% of Calvert County's 6 members or Garrett County's 5 members is required. If the member sends his resolution through the Component Society, only the majority vote of the quorum is required. In Baltimore City Medical Society 23 votes of a 45 member quorum is required; in Calvert County component 30% of the vote of 6 members is required; and, in Garrett County of 5 members, etc.

A resolution should require no more than the signature or motion of the member or members introducing it.

Further, Lloyd E. Smith in his *A Manual of Parlia-*

mentary Law demonstrates that accepted parliamentary procedure supports this: "Each member, being a fully recognized member of a body, has an equal right with his neighbor to initiate action, discuss questions, make objections, vote—in short, to do anything that any other member may do. No member should attempt to curtail the freedom of any other member in this respect; and, conversely, all members should respect the rights of any one member, which must always be equal to, and never less nor more than, their own rights."

On the basis of the preceding, it is clear that our Med-Chi bylaws are in need of amendment.

1. To establish true equality of representation proportional to the membership of components.
2. That each member or group of members through his or their signature, may through his or their representatives introduce a motion or resolution for consideration and disposition by the entire House of Delegates or its quorum.

Our license for medical practice is based on professional qualifications and conduct; and as members of the profession, equality of right to practice must be matched by equality of voting.

Sincerely,
M. B. Levin, MD

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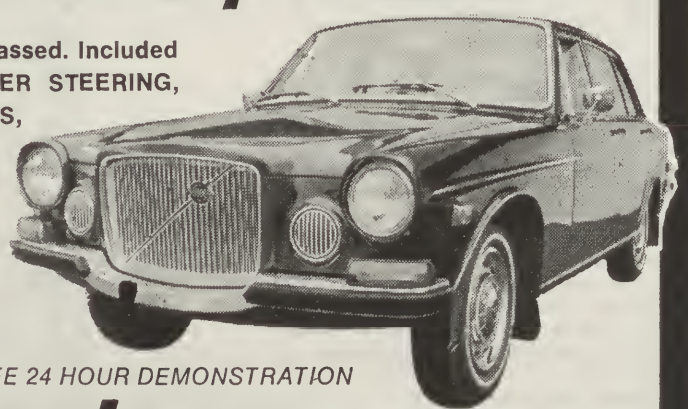
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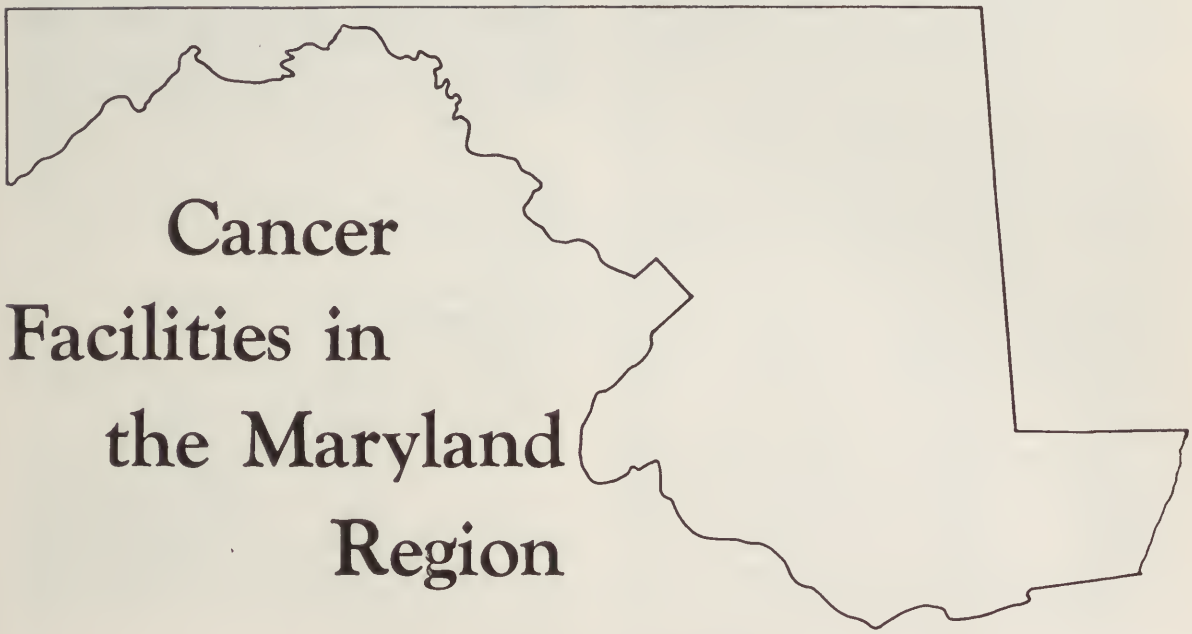
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Facilities for the diagnosis and treatment of the cancer patient are not equally available in hospitals in the Maryland region. Of 37 short-stay non-federal general hospitals surveyed in the region, 18 were found lacking in comprehensive services for the diagnosis of cancer, and only 8 hospitals reported complete diagnostic and therapeutic services for the cancer patient. This article reports on the availability of selected cancer services and facilities in the hospitals surveyed, with suggestions for equalizing the availability of services to the cancer patient throughout the Maryland region.



Cancer Facilities in the Maryland Region

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Although the area included under the jurisdiction of the Maryland Regional Medical Program differs from that of the State of Maryland*, an approximation of the magnitude of the cancer problem in the region can be gained by using morbidity and mortality data for the state. In 1960, an estimated 7,160 Maryland residents were diagnosed for the first time as having cancer (Table 1). In this same year almost 18,000 patients known to have cancer were alive during part or all of the year. Among these 18,000 were patients who were diagnosed as having cancer before 1960 and those who were first diagnosed with cancer during 1960.

* *The Maryland region consists of all of the counties in the State of Maryland with the exception of Montgomery County, but includes, in addition, York County, Pa., the Southern half of Sussex County, Del., and the Northern tip of Accomack County, Va.*

Table 1: Estimated Incidence and Prevalence of Cancer in Maryland, 1960

Location	Incidence		Prevalence	
	Number	Rate per 100,000	Number	Rate per 100,000
Maryland	7,160	230.9	17,910	577.7
Baltimore	2,540	270.5	6,350	676.2
Rest of State	4,620	213.8	11,560	534.9

Source: Department of Chronic Diseases, The Johns Hopkins School of Hygiene and Public Health

The death rate from cancer has increased from 139.8/100,000 in 1950 to 152.6/100,000 in 1967. Of the 5,635 cancer deaths recorded in 1967, almost half were due to malignancies of the digestive system (Table 2). Although almost two thirds of all the cancer deaths were residents of the counties outside of Baltimore city, the death rate for residents in Baltimore was 50% higher than that in the counties.

Table 2: Cancer Mortality in Maryland, 1967

Item	Number of Deaths	Rate per 100,000	Item	Number of Deaths	Rate per 100,000
Total	5,635	152.6	Race		
			White	4,678	152.6
			Nonwhite	957	152.8
Sex			Location		
Male	3,066	168.1	Baltimore	1,945	213.8
Female	2,569	137.5	Rest of state	3,690	132.6
Age			Site		
under 5	27	7.0	Digestive	1,565	42.4
5-17	61	6.1	Respir.	1,197	32.4
18-44	421	31.8	Genital	714	19.3
45-64	2,279	317.3	Breast	513	13.9
65 +	2,847	1047.4	All other	1,646	44.6

Source: Vital Statistics—Maryland State Health Department Annual Report, 1967

One of the primary aims of the Regional Medical Program is to make available to patients the latest advances in the diagnosis and treatment of cancer. To ascertain the state of the art, so to speak, with respect to manpower and facilities, a survey was conducted in the spring of 1968 covering 41 short-stay non-federal general hospitals in the Maryland region. The 29 hospitals with 100 beds or more were visited; those hospitals with less than 100 beds received copies of the survey form by mail after telephone contact with the hospital administrator. In all the hospitals in the survey, the point of central contact for the information was the hospital administrator. Parenthetically, it should be pointed out that at the outset the mission of the Maryland Regional Medical Program was explained. It was stressed that the data to be collected in the survey would be useful for purposes of planning and evaluation not only for the staff of the Regional Medical Program, but also for administrators and boards of trustees in hospitals. The data obtained refer to the last six months of 1967.

Data was received from 37 of the 41 short-stay general hospitals in the Maryland region. The four hospitals from which no data was obtained were under 100 beds in size and were located outside of the Baltimore metropolitan region. Table 3 gives the distribution of the hospitals in the Maryland region by geographic area and number of beds.

Table 3: Short-Stay Non-Federal General Hospitals[1] Included in Survey by Geographic Area and Size, Maryland Region, 1968

Geographic Area	Total	Bed Size: Under 100	100-199	200-299	300-399	400 or more
All Areas	41	12	10	4	9	6
Baltimore Region[2]	22	2	7	3	5	5
Eastern Shore	6	3[3]	2	..	1	..
Western Maryland	6	2	1	1	2	..
Prince George's County	3	2[4]	..	..	1	..
Southern Maryland	3	3[5]	..	..	..	..
York, Pennsylvania	1	..	..	..	..	1

[1] *Includes only non-profit hospitals.*
[2] *Includes Baltimore city and County, Anne Arundel, Harford and Carroll counties.*
[3] *Survey form not received from 1 hospital.*
[4] *Survey form not received from 2 hospitals.*
[5] *Survey form not received from 1 hospital.*

Information obtained from the survey relating to cancer services and facilities included: 1) tumor boards and tumor registries; 2) selected cytological and radiological diagnostic programs; and, 3) selected therapeutic services.

Tumor Boards and Tumor Registries

Tumor boards and tumor registries are activities set up by the hospital's medical staff principally to aid physicians in the diagnosis and treatment of cancer patients. These activities are included in the requirements established by the American College of Surgeons for approval of a hospital cancer program.[1] Members of a tumor board systematically review suspected or proven cases of cancer with a twofold purpose in view: 1) to insure that the patient receives the prescribed levels of care, and 2) to serve as a manpower source for consultation to physicians requiring such services. A well-functioning tumor registry insures adequate follow-up of cancer cases discharged from the hospitals, encourages analysis of various methods of treatment of cancer, and lends perspective on the measurement of the size and nature of the cancer problem in the hospital, as well as the evaluation of the quality of care given cancer patients. The presence of a tumor board or a tumor registry or both in a hospital reflects, therefore, an interest among the hospital staff in the continuing improvement of the quality of care given the cancer patients.

In the Maryland region, 14 hospitals reported having a tumor board or a tumor registry or both (Table 4). The 14 hospitals included 11 in the Baltimore metropolitan region and 3 in the region outside of Baltimore. Eleven of the 14 hospitals had both a tumor board and a tumor registry. Tumor boards and registries are less likely to be found in small hospitals and as expected, 20 of the 22 hospitals with under 300 beds reported having neither a tumor board nor a tumor registry.

Table 4: Hospitals Reporting Tumor Board or Tumor Registry by Hospital Size, 1967

Hospital Size (BEDS)	No. of Hosp.	Tumor Board & Tumor Reg.	Tumor Board Only	Tumor Reg. Only	None: No.	None: % of Total
Total	37	11	1	2	23	62.1
Under 300	22	1	..	1	20	90.9
300-399	9	5	1	..	3	33.3
400 and over	6	5	..	1	..	..

Diagnostic Services

The diagnosis of cancer is second in importance to prevention, and indeed may be a part of prevention. Although it is recognized that the prerequisites for early and efficient diagnosis of cancer include a diagnostic team composed of physicians trained in oncology, and a capable allied health professional staff, in addition to a well-equipped and efficiently functioning clinical laboratory and radiology department, the discussion in this section will be limited to the findings of the survey pertaining to the diagnostic services of the laboratory and radiology departments. For the most part, the tests reported were used to establish diagnosis and extent of disease in ill patients and, with possibly one exception, were not used as a screening procedure to detect disease in asymptomatic individuals. In this report, the procedures will be grouped according to the technique involved: 1) cytologic, including cervical cytology, bronchial cytology, stomach cytology and bone marrow studies; 2) radioisotope scans; and 3) other radiologic procedures including mammography and tomography.

The number of hospitals reporting these diagnostic services is shown in Table 5. In general, more hospitals reported performing the selected cytological procedures than the selected radiological procedures with the least number of hospitals reporting the availability of radioisotope scans program for their patients. The diagnostic services were reported by a larger proportion of hospitals in the Baltimore metropolitan region than by hospitals outside this region.

Table 5: Selected Diagnostic Services in 37 Short-Stay Non-Federal General Hospitals in the Maryland Region by Geographic Area, 1967

Diagnostic Services	Number of Hospitals Reporting			Percent of Total		
	Maryland Region	Baltimore Region	Maryland Region excl. Baltimore	Maryland Region	Baltimore Region	Maryland Region excl. Baltimore
Total Hospitals	37	22	15	100.0	100.0	100.0
Cervical Cytology	35	22	13	94.6	100.0	86.7
Bronchial Cytology	32	21	11	86.5	95.4	73.3
Stomach Cytology	22	14	8	59.4	63.6	53.3
Bone Marrow Study	32	21	11	86.8	95.4	73.3
Radioisotope Scans	20	13	7	54.0	59.1	46.7
Mammography	24	17	7	64.8	77.2	46.6
Tomograms	25	17	8	67.5	77.2	53.3

Cytological Procedures

Table 6, which gives the range and the median number of cytological tests performed according to hospital-bed size, is illustrative of the great variation in the use of these tests among hospitals. There is a wide range in the frequency with which each procedure was performed regardless of hospital-bed size classification. In every instance, the median number of tests performed increases with hospital size. Cervical cytology was by far the most frequently performed cytological procedure. Bronchial cytology was next in order of frequency followed by bone marrow studies and stomach cytology. The order of magnitude of these tests can be illustrated by a comparison of the median number of cervical cytological tests performed with each of the other tests for each hospital-bed size. Thus, by hospital size, the medians for cervical cytology are approximately 15 to 20 times larger than those for bronchial cytology, 30 times greater than those for bone marrow studies, and 70 to 90 times larger than those for stomach cytology. To illustrate, for hospitals in the 300 to 399 bed size category, for every 1,000 cervical cytological tests performed, there are about 50 bronchial, 35 bone marrow, and 15 stomach cytological tests performed.

Table 6: Frequency of Cytological Diagnostic Procedures Reported by Short-Stay Non-Federal General Hospitals in the Maryland Region By Size, July-December 1967

Hospital Size	Range		Median
	Low	High	
	Cervical Cytology		
Under 300	4	5,059	476
300-399	181	4,389	1,618
400+	1,846	10,621	4,547
	Bronchial Cytology		
Under 300	2	200	20
300-399	40	400	88
400+	59	1,061	325
	Stomach Cytology		
Under 300	1	30	4
300-399	2	200	23
400 +	6	117	48
	Bone Marrow		
Under 300	2	48	12
300-399	18	85	55
400 +	62	369	148

Radioisotope Scans

The use of radioisotope scans as a diagnostic procedure was reported by 20 hospitals in the Maryland region. Thirteen of these are in the Baltimore metropolitan region and seven outside of this region.

In the diagnosis of cancer, radioisotope scans are used for the most part to detect neoplasms of the head, thyroid, and liver.* Scans of these three sites accounted for more than three out of every four scans performed in the hospitals in the Maryland region. The remainder of the scans were performed to detect conditions other than neoplasms and involved the kidney, lung, stomach, pancreas, and other organs. The distribution of radioisotope scans by site is shown in Table 7. For the region as a whole, more head scans were done than for any other site with thyroid next in frequency. However, when one compares the hospitals in the Baltimore metropolitan region with hospitals outside the region, it may be seen that 1) radioisotope scans are performed much more frequently in the former than in the latter, and 2) the two leading categories were head and liver in the Baltimore metropolitan region hospitals, while in the other hospitals, thyroid was by far the largest category with head next in order of frequency. The observed differences are probably due to, firstly, the presence of more sophisticated equipment in the Baltimore hospitals, and secondly, more physicians in the Baltimore area knowledgeable in the newer application of nuclear medicine.

Table 7: Number of Radioisotope Scans Per 100 Beds by Site, Short-Stay Non-Federal General Hospitals, Maryland Region July-December, 1967

Site	Maryland Region	Baltimore Metropolitan Region	Maryland Region excluding Baltimore
Total	125.4	144.3	73.7
Head	46.2	55.7	20.5
Liver	24.0	30.3	6.9
Kidney	6.8	6.5	7.6
Thyroid	27.9	27.8	27.9
Other	20.5	24.0	10.8
No. of Hosp.	20	13	7
No. of Beds	7,537	5,512	2,025

Table 8 shows the range and median number of radioisotope scans for selected sites by hospital-bed size for the last six months of 1967. It can be seen that the median number of head scans increased as hospital-bed size increased, with 60 in the smaller hospitals to 205 in the larger hospitals. Thyroid scans ranged from 16 to 300 also increasing with hospital size. However, this increase was neither uniform nor gradual. For example, hospitals with 400 beds or more had a median number of 255 thyroid scans performed in the report period, while for hospitals with 300 to 400 beds the median was 68, and for hospitals with less than 300 beds the median was 56 scans, a number close to that for the next larger hospitals. The use of thyroid scans for many other purposes than just the detection of neoplasms may account for the relatively large number performed in hospitals with 400 beds or more. Liver scans ranged from 4 in one hospital to 450 in another. Comparison of liver scans by hospital-bed size shows that the median number of scans for hospitals with 300 beds or more is significantly greater than those in hospitals with less than 300 beds.

Table 8: Selected Radioisotope Scans Reported by Short-Stay Non-Federal General Hospitals in the Maryland Region by Size, July-December 1967

Hospital Size	Range		Median
	Low	High	
	Head		
Under 300	10	130	60
300-399	9	171	139
400+	50	767	205
	Thyroid		
Under 300	16	77	45
300-399	32	105	68
400+	102	300	255
	Liver		
Under 300	10	70	23
300-399	4	105	90
400+	34	450	90

* *It is realized that in many instances scans of the liver and thyroid are performed to detect conditions other than neoplasms.*

Other Radiological Procedures

Table 9 shows the frequency with which mammograms and tomograms were reported for the last half of 1967. The median number of tomograms was greater than that for mammography. This was true for hospitals of all sizes.

Although mammography was performed in two out of every three hospitals in the Maryland region, the number of these tests performed in most of the hospitals during the six-month period was small. In addition, the usual relationship of increase in number of tests performed with increase in hospital size did not

Table 9: Selected Special Radiological Diagnostic Procedures Reported by Short-Stay Non-Federal General Hospitals in the Maryland Region by Size, July 1967-December 1967

Hospital Size	Range		Median
	Low	High	
	Mammography		
Under 300	1	29	7
300-399	3	123	30
400+	4	112	24
	Tomograms		
Under 300	4	94	23
300-399	16	304	78
400+	17	500	175

prevail. Thus, the median number of mammographies performed by hospitals with 300-399 beds was 30 compared to 24 for hospitals with 400 or more beds.

Factors accounting for both the small number of mammograms taken in some hospitals, and the variation in the frequency among hospitals may include: 1) a lack of consensus among physicians on the efficiency of mammography as a diagnostic test; 2) physicians may not be as knowledgeable as one would expect in the use of mammography as a screening test; and 3) the criteria used by physicians as to the acceptability of patient risk to X-ray exposure precludes the use of the test.

Tomography ranked third as a procedure reported by the hospitals, and the median number of tomograms performed increased with hospital size. It is of interest to note that the frequency with which tomograms are performed approximates that for bronchial cytology. This is not surprising since one of the principal uses of the tomogram is to stage neoplasms of the chest.

Cancer Therapy

Chemotherapy: In Table 10, it may be seen that two out of every three hospitals in the Maryland region reported the use of chemotherapy in the treatment of cancer patients. As would be expected, a greater proportion of the hospitals in the Baltimore region use chemotherapy than do those in the region outside of Baltimore, and the proportion of hospitals reporting the use of chemotherapy increased with increasing hospital size. All hospitals with 300 beds or more reported using some type of chemotherapy.

Table 10: Cancer Chemotherapy Facilities Reported by 37 Short-Stay Non-Federal General Hospitals in the Maryland Region, 1967

Item	Hospitals Reporting	Hospitals with Chemotherapy	
		No.	Percent
TOTAL	37	25	67.5
Geographic Area			
Baltimore Region	22	17	77.2
Maryland Region excl. Baltimore	15	8	53.3
Hospital Size			
Under 100	8	1	12.5
100-199	10	6	60.0
200-299	4	3	75.0
300 and over	15	15	100.0

Therapeutic Radiology: Only 16 of the 37 hospitals in the entire area reported having radiological therapy facilities (Table 11). Superficial therapy or orthovoltage was reported by 11 hospitals, 6 of which were located outside of Baltimore. Of major importance is the fact that there are five cobalt-60 teletherapy units in the Maryland region. Four are located in the City of Baltimore and one is in Cumberland.

Table 11: Radiological Therapy Facilities in 37 Short-Stay Non-Federal General Hospitals, Maryland Region, 1968

Hospital Size (Beds)	Maryland Region			Baltimore Region			Maryland Region Excluding Baltimore Region		
	St			St			St		
	SV or Ov		None	SV or Ov		None	SV or Ov		None
Total	5	11	21	4	5	13	1	6	8
Under 100	—	—	8	—	—	2	—	—	6
100-299	1	4	9	—	3	7	1	1	2
300-399	1	6	2	1	2	2	—	4	—
400 and over	3	1	2	3	—	2	—	1	—

Abbreviations: SV—Supervoltage
St—Superficial Therapy
Ov—Orthovoltage

Overall Facilities

To be able to consider the foregoing discussion in the proper framework, it is necessary to assess the hospitals in the Maryland region in terms of the total facilities in each hospital which are available for the diagnosis and treatment of cancer patients. In Table 12, hospitals are classified according to the reported presence or absence of the various diagnostic and therapeutic facilities. Although the facilities considered are not all inclusive, their presence in a hospital is being used as an index of completeness of the diagnostic services in a hospital. For example, a hospital where cytological tests are performed, but not radioisotope scans, would be considered as not having complete diagnostic services.

Table 12: Programs for Cancer Patients in 37 Short-Stay Non-Federal General Hospitals in the Maryland Region, 1967

Combination of Complete Programs (X Present, — Absent)			Number of Hospitals with Indicated Combination of Programs by Location		
Tumor Board or Registry	Diagnostic	Therapeutic	Total	Balto. Metro. Region	Md. Region excluding Baltimore
X	X	X	8	5	3
X	X	—	4	4	—
—	X	X	2	1	1
X	—	—	2	2	—
—	X	—	5	3	2
—	—	X	3	1	2
—	—	—	13	6	7

Only 8 of the 37 hospitals surveyed in the Maryland region have facilities for the diagnosis and treatment of cancer which may be considered complete. If the criteria for completeness include the presence of a cobalt-60 teletherapy unit then this number is reduced to only four hospitals, all located in Baltimore city. It is important to note that 13 of the 37 hospitals included in this survey had none of the facilities. (Included in this group are some hospitals which had

diagnostic or therapeutic programs not considered complete according to the criteria established above.) If one adds to this the five hospitals which had either a tumor board or therapeutic services, but no diagnostic program, it becomes evident that almost half of the hospitals in the Maryland region lack complete diagnostic facilities for cancer.

Discussion

The activities and functions of the Regional Medical Program may be used to correct to some extent the deficiencies and unevenness of hospital services for the cancer patient. For the most part, these activities and functions include the initiation of cooperative arrangements between hospitals, the institution of continuing education programs for medical and allied health professionals, and the training of new personnel to relieve manpower shortages.

Tumor Boards and Registries: In the case of tumor boards and tumor registries, cooperative arrangements between the "haves" and the "have nots" could take the form of jointly-sponsored tumor boards, cancer registries and cancer clinics. In addition, the hospitals with specialists, such as radiotherapists, urologists, etc., could make their services available for consultation to the cooperating hospitals. A central tumor registry could be established among the cooperating hospitals with the long-range view of forming such a registry for the entire region to be followed by the merging of tumor registries among regions contiguous to the Maryland region.

In the subregions outside of the Baltimore area, an additional type of cooperative arrangement may be desirable. Specifically, subregional centers could be established in strategic cities on the Eastern Shore and in Western Maryland. This type of arrangement might lead to the formation of a bond among the hospitals which could ultimately result in the pooling of scarce services in the area. In time, arrangements on a subregional basis would restructure the role of the universities so that their expertise would be needed in unusual cases only. In this connection, the Maryland Regional Medical Program is conducting a demonstration program linking The Johns Hopkins Hospital and the Memorial Hospital in Easton to make available immediate consultation for difficult cancer cases. In addition, a single cancer registry is being developed for the two hospitals as part of this program.

A number of basic difficulties are recognized to establish cooperative arrangements. For example, hospitals may not wish to be classified as satellites; these hospitals feel that in making such arrangements they are taking orders, so to speak, from another hospital, although a major one, in the area. In addition, physicians may hesitate to take time from active patient care to work on tumor boards and tumor registries. Thirdly, many hospitals lack permanent staff with the result that the operation of the program would be left entirely to the attending physician or surgeon. A system of incentives may overcome these difficulties. Such incentives might include federal or state support for the establishment and operation of the registry and payment to physicians for overseeing its operation. In addition, continuing education for the hospital staff, detailing the benefits of the tumor board and tumor registry approach to the diagnosis and treatment of the cancer patient, should be encouraged and partially supported by state or federal funds.

Cytology: In the case of cervical cytology, the relatively large number of examinations that were performed reflects the acceptance of this test by the medical profession for use in both asymptomatic and symptomatic patients. However, when used as a screening device, many of the hospitals limit their efforts to outpatient clinic patients and still others to gynecological patients only. An intensive educational and demonstration program, involving the two universities and the State Health Department, is needed to encourage all hospitals to institute a policy which would require routine cervical smears on all adult female patients age 20 and over, whether inpatient, outpatient, or emergency patients. Since many of the patients will not be treated for gynecological conditions, it is proposed that no charge for this service be made and that the hospital be reimbursed for this service using state or federal funds.

The frequency with which bronchial cytology*, stomach cytology, and bone marrow studies are performed is much less than for cervical cytology since they are usually done only when indicated. However, it seems unlikely that the variation among hospitals in the number of admissions of cancer patients, where the site involved is one of these organs, can account for the variation in the number of times these tests are performed. A continuing education program for physicians stressing the indications for these tests could do much to minimize this variation.

Finally, much of the success of screening tests of this nature depends on the availability to the staff of competent cytotechnologists, and programs are needed to train such personnel. Present training programs in hospitals where such activities are on-going should be augmented. These training programs should also be supported by means of federal or state funds.

Radioisotope Scans: The use of radioisotope scans as a diagnostic technique for cancer is relatively new, and as a result qualified manpower in this area is in short supply. This need could be met through training programs in nuclear medicine for physicians which should be instituted by the two universities. In addition, technologists and technicians should be trained

* *The use of sputum cytology as a screening device was not investigated.*

and information disseminated to the hospitals as to where this training may be obtained. The Maryland Hospital Council should be encouraged to play a large part in the training of these allied health professionals. A recognized authority in nuclear medicine has suggested that radioisotope facilities should be located in each hospital for routine cases. For difficult cases, cooperative arrangements should be made with the university hospitals.

Chemotherapy: Considerably more information is needed concerning the type of chemotherapy programs in the hospitals since it is common knowledge that hospitals vary greatly with respect to the quality and quantity of these services. The Regional Medical Program could contribute to the increased efficiency in the use of chemotherapy by establishing a central registry which will contain specific information on the use of chemotherapy, by type of agent used, type of patient illness, and evaluating the chemotherapeutic treatment in terms of outcome. In fact, this information should be a part of the cancer patient registry, thus becoming a source of information to the physicians as to the effectiveness of the agents being used. This would increase the efficiency in the use of the various chemotherapeutic agents and probably improve the quality of care of cancer patients. A program of continuing education in the uses of chemotherapy could supplement this program.

Radiotherapy: The fact that only 16 of the 37 hospitals surveyed offer radiotherapeutic services to cancer patients does not necessarily mean that steps should be taken to make these services available in the remaining 21 hospitals. Rather, an intensive study is needed to indicate where such services would be justified. In those rural areas where it is determined that the installation of radiotherapeutic equipment is not justified, steps should be considered to make it easier for those patients who would have to travel or otherwise be away from their homes to receive such services. Many patients forego treatment because of the time it takes to travel to Baltimore or other central locations where this service is available, or because of the difficulties entailed in being separated from their families for extended periods of time. Thus, fast transportation such as a helicopter, or temporary low-cost housing should be investigated as possibilities for alleviating these difficulties.

The problem of the shortage of personnel with expertise in radiotherapy is an important one. To remedy this defect, the Maryland Regional Medical Program should sponsor training and continuing education programs for both physicians and radiotechnologists. Further, the Maryland Regional Medical Program should encourage cooperative arrangements among the major hospitals in the region and the smaller community hospitals to make consultative services available when needed. Finally, a program should be instituted whereby physicians report to a central registry the type and amount of radiotherapy given for each cancer patient treated. This information could then be analyzed and be made available to physicians as a guide in the further treatment of their patients.

Summary

1. A manpower and facilities survey of short-stay non-federal general hospitals in the Maryland region was conducted in March 1968. The data collected from 37 hospitals included information on diagnostic and therapeutic facilities for cancer.

2. Only 14 hospitals reported having a tumor board or tumor registry and 11 of these were located in the Baltimore metropolitan region.

3. Among the selected diagnostic procedures, cervical cytology was reported by more hospitals (35) and performed more frequently than any other procedure. At the other end, radioisotope scans were accomplished in only 20 hospitals.

4. In general, the median number of the selected diagnostic procedures performed increased with increase in hospital size. However, there was great variation in the number of procedures performed in each hospital size group.

5. Four of the five cobalt-60 teletherapy units in the Maryland region are located in Baltimore.

6. Complete diagnostic and therapeutic services for the cancer patient, including a tumor board and tumor registry are available in eight hospitals and only four of these have cobalt-60 teletherapy units.

7. Almost half of the hospitals in the region lack complete diagnostic facilities for cancer patients.

8. Methods suggested for improving the delivery of diagnostic and therapeutic services for the cancer patient include cooperative arrangements between hospitals for the diagnosis and treatment of patients, continuing education programs for physicians, and training programs for allied health professionals.

REFERENCE

1. Manual for Cancer Programs, American College of Surgeons, 1961.

Expedient and accurate diagnosis has been the keystone of proper treatment in cases of carcinoma of the uterine cervix. Since, at present, "conization biopsy" is most often used to determine the extent of the many lesions, such a method for rapid evaluation of the excised cervical tissue, with the primary aim being the elimination of diagnostic delays, is of great importance.

The Cryostat Cone

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Prior to use of the cryostat, the standard procedure for studying cone biopsies included excision of the tissue with the patient under general anesthesia and a postconization hospital stay of 24 to 48 hours, for processing and evaluation of the material. If the pathological study revealed an operative lesion, definitive surgery was performed within 48 hours after conization, or delayed for four to six weeks (therapy in either case necessitating a second general anesthesia). The longer the period between conization and surgery, the higher the rate of morbidity. Using this standard approach, VillaSanta and Durkan [1] studied 200 "cold conization" cases and found a complication rate of 12%, including 20 postoperative hemorrhages, one pelvic abscess, one severe cystitis, and two "abortions". Seven of the patients who experienced severe bleeding required one or more units of blood.

Rutledge and Ibanez [2] reported 70 cases in which the cryostat sections were used to evaluate conization specimens. They reported excellent correlation between the results obtained from the frozen and permanent sections. In three cases, however, residual tumor was found in the removed uterus. This finding was attributed to inadequacy of the sample material rather than to inaccuracy in diagnosis of the frozen section.

Kaufman and co-workers [3] found that in 49 of their 52 cases, there was agreement in the diagnosis between frozen and permanent sections. The minor differences in degree of atypism did not alter the type of therapy given. The average hospital stay for those patients having the conized specimen sectioned on the cryostat and a hysterectomy performed if necessary, under the same anesthesia, was 7.8 days with a morbidity of 28%. Conversely, those patients who had conization followed approximately 48 hours later by hysterectomy, ie, two anesthetics, remained in the hospital 9.2 days and had an 86% morbidity rate. The average time from removal of the cone to the cryostat report was 20 to 40 minutes.

Dutra [4] reported 166 cases in which the conized tissue was studied by frozen section technique. Guerriero and his colleagues [5] recorded 150 cases and felt that the correlation of diagnosis between frozen and permanent sections was excellent. Greenberg and Kaufman,[6] Kaufman, Janes, and Cox [7] published a follow-up of their initial experiences of 1962. A total of 210 cases was studied. These authors concluded that the patients who had "frozen section cone" followed by hysterectomy under the same anesthesia had less morbidity than the group for which therapy was delayed 48 hours while awaiting permanent sections. They also found that the difference in diagnosis between the frozen and permanent sections in 14 cases was minor and did not alter treatment. Finally, any discrepancy in results obtained from the frozen section diagnosis and the cytologic study should delay

For Rapid Diagnosis

in Carcinoma of the Uterine Cervix

any treatment until permanent sections could be evaluated.

Study Material and Methods

The Gynecological Pathology Laboratory of The Johns Hopkins Hospital made a study between October 1965, and June 1967, and a total of 40 cervical cone specimens were sectioned on the cryostat. This study group was compared with a control group of 40 specimens evaluated by the standard procedure.

The usual criteria for performing conization were followed. The cytologic study in all cases prior to conization showed inconclusive and bizarre cellular changes of varying degrees of severity. Most cervices had had prior biopsy and colposcopy, neither study demonstrating any definitive evidence of invasive epidermoid carcinoma.

The usual preoperative study was carried out and preparation for conization was similar in both groups of patients. This study included history and physical exam, chest X-ray, electrolytes and serum urea nitrogen, and EKG (when indicated). The vagina was cleansed with an alcohol wash and, prior to surgery, the entire area was studied thoroughly with Schiller's or Lugol's solution. The pathology laboratory was notified 24 hours in advance of an impending cryostat cone.

The conization biopsy was performed following ligature of the descending branches of the uterine arteries. Great care, of course, was taken not to manipulate the portion of the cervix to be sent for evaluation. Following conization, dilatation of the cervix and curettage of the endometrium were performed. Sturmdorf-type sutures were placed, and routine preparation for either abdominal or vaginal procedure was carried out in anticipation of a possible hysterectomy.



Fig. I: Conized specimen. The suture marks "12 o'-clock; ie, the apex of the anterior aspect of the cervix, the point at which the canal is opened.

Each specimen was opened at "12 o'clock", wrapped in a saline-soaked sponge, and delivered to the Gynecological Pathology Laboratory by a special cable. The specimen was cut into four labeled sections as follows:

Section A	**12-3 o'clock**
Section B	**3-6 o'clock**
Section C	**6-9 o'clock**
Section D	**9-12 o'clock**



Fig. II: The three sections into which each quarter is usually divided: A—12-3 o'clock; B—3-6 o'clock; C—6-9 o'clock; D—9-12 o'clock.

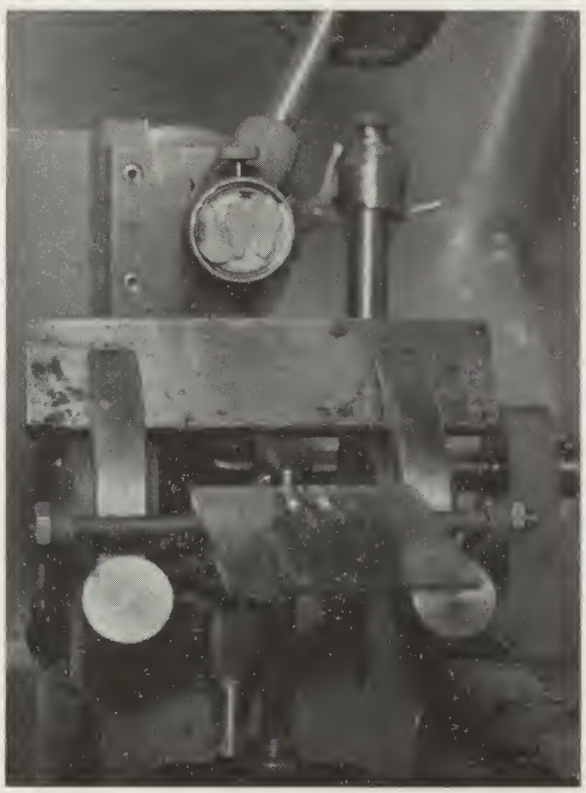


Fig. III: Sections from each quadrant, usually three, are (left) fixed on the holder, with "cyto-fix", frozen in the cryostat (often with the aid of the CO_2 spray), and situated so that the microtome blade attacks the long axis of the specimen; ie, perpendicular to the epithelial surface.

Each section was cut into two or three segments and placed on a cryostat stage, with the mucosal surface at right angles to the microtome blade. The stages were placed in the cryostat unit for quick freezing at —20°C to —30°C. Two to four sections (7 to 10 microns) were cut from each section and stained with hematoxylin and eosin. As the team, usually consisting of a technician and two others, carried out these procedures, the pathologist-in-charge read the sections. After complete evaluation, a telephone report was returned to the surgeon.

The entire procedure from surgery to report was accomplished in 20 to 30 minutes. All frozen sections were verified the following day by paraffin sections and in all cases the hysterectomy specimen was given similar close scrutiny.

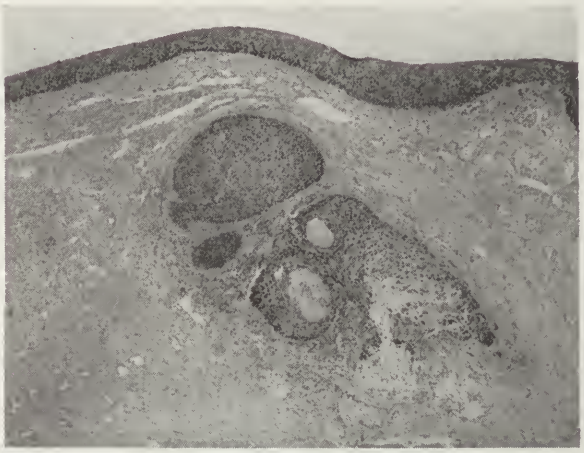


Fig. IV: Permanent section with surface carcinoma in-situ, gland involvement, and early stromal invasion.

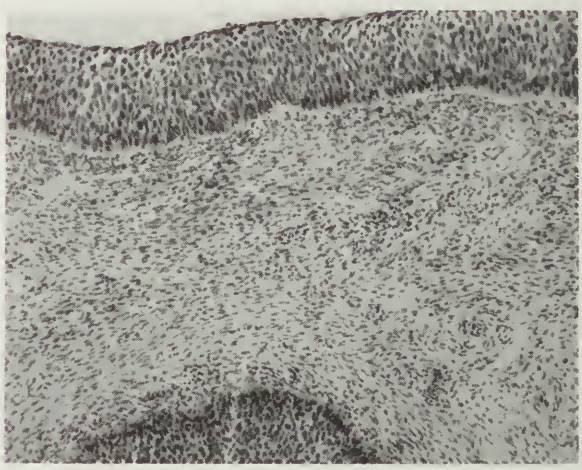


Fig. V: Cryostat section from same quadrant seen in Fig. IV.

Results

The results of this study showed considerable correlation in interpretation between permanent and frozen section specimens (Table 1). Where disagreement existed, such deviations were minor and in no case influenced the ultimate therapy.

The morbidity, as defined by a temperature elevation of 100.4° or above, 48 hours or more postoperative, was significantly less in the frozen section group than in the control group. The average hospital stay for those treated immediately after cryostat evaluation and subsequent surgery was 8.8 days as compared to 10.2 days in the control group (see Table 2). The number of patients requiring antibiotic therapy was greater in the control group as compared to the "cryostat study" patients.

The methods of treatment in the two groups are compared in Table 3. It is readily apparent that, in general, treatment was the same in both; however, a significantly increased number of vaginal hysterectomies were performed in the "cryostat study group," as compared to the abdominal approach in the control group.

In our small series, the diagnoses of frozen section material varied widely from cervicitis chronic to invasive epidermoid carcinoma. Three of the patients were also pregnant at the time of conization.

Table 1: Comparison of Cryostat and Permanent Sections

NAME	AGE	PARITY	CRYOSTAT	PERMANENT
1. E.R.	33	0-0-1-0	ICO, poss. micro-inv.	ICO, poss. micro-inv.
2. C.A.	51	2-0-0-2	ICO, glands	Atypia, mod. or worse
3. H.M.	42	5-0-0-5	ICO, glands	ICO, glands
4. B.H.	40	6-0-0-6	ICO, min. strom. inv.	ICO, min. strom. inv.
5. H.H.	30	6-0-0-6	ICO, glands	ICO, glands, prob. micro-inv.
6. M.B.	45	5-0-0-5	ICO	ICO, poss. micro-inv.
7. H.S.	23	3-0-0-3	Mod. atypia	Mod. to mkd. atypia
8. C.H.	50	1-0-0-1	ICO, glands	ICO, glands
9. S.B.	40	3-0-1-3	Mkd. atypia	Mkd. atypia
10. J.J.	31	3-0-2-3	ICO, glands	ICO, glands
11. D.D.	31	4-0-0-4	ICO, min. strom. inv.	ICO, min. strom. inv.
12. L.C.	53	3-1-0-3	ICO, poss. micro-inv.	ICO, poss. micro-inv.
13. P.K.	29	9-0-0-9	Mod. to mkd. atypia	Mod. to mkd. atypia
14. G.H.	29	6-0-3-5	ICO, glands	ICO, glands
15. E.L.	35	4-0-0-4	Mkd. atypia	Mkd. atypia
16. A.J.	22	5-0-0-5	ICO	ICO
17. F.C.	60	1-0-0-1	Micro-invasion	Micro-invasion
18. D.B.	33	2-1-1-3	ICO, glands	ICO, glands
19. L.M.	55	0-0-0-0	Inv. epidermoid ca.	Inv. epidermoid ca.
20. A.C.	25	Unknown	ICO, poss. micro-inv.	ICO, glands
21. V.C.	40	Unknown	ICO, poss. micro-inv.	ICO, poss. micro-inv.
22. N.L.	48	6-1-5-7	Cervicitis chronic	Mod. atypia
23. G.L.	33	5-0-0-5	Cervicitis chronic	Cervicitis chronic
24. S.V.	28	Unknown	ICO, glands	ICO, glands
25. D.C.	31	Unknown	ICO, poss. micro-inv.	ICO, poss. micro-inv.
26. J.E.	31	5-0-0-5	Mild to mod. atypia	Mild atypia
27. M.B.	26	4-0-1-4	Mild atypia	Mod. atypia
28. F.R.	32	0-0-0-0	Mod. to mkd. atypia	Mod. atypia
29. J.L. P	34	4-4-2-7	ICO, glands	ICO, glands
30. M.T.	29	7-0-0-7	Mild atypia	Mild atypia
31. J.T. P	31	1-4-0-5	ICO, glands	ICO, glands
32. C.M.	27	1-1-0-3	ICO, glands	ICO, glands
33. B.N.	34	6-0-0-6	Mkd. atypia	Mkd. atypia
34. C.S.	33	6-1-0-6	Cervicitis chronic	Mod. atypia
35. B.F. P	24	1-5-0-6	ICO, glands	ICO, glands
36. M.W.	21	3-0-0-3	Cervicitis chronic	Cervicitis chronic
37. L.C.	41	0-1-0-0	ICO, glands	ICO, glands
38. M.B.	33	3-0-1-3	ICO	ICO
39. V.M.	41	1-0-0-1	Inv. ca.	Inv. ca.
40. B.M.	38	7-0-1-7	ICO, glands	ICO, poss. micro-inv.

P=Pregnant

Key:

ICO	Intraepithelial carcinoma of the cervix (International Classification, Stage 0).
ICO, glands	Intraepithelial carcinoma of the cervix with glandular involvement.
ICO, min. strom. inv.	Less than four mm of stromal invasion (from the basement membrane and measured with micro-calipers).
Micro-invasion	Minimal stromal invasion.
Mild atypia	Anaplasia involving less than ⅓ the thickness of the epithelium.
Moderate atypia	Anaplasia involving ½ or less the thickness of the epithelium.
Marked atypia	Anaplasia involving more than ½ but not the entire thickness of the epithelium.

Table 2: Length of Hospitalization and Morbidity in Cryostat and Control Groups

	Length of Hospitalization*	Morbidity Temperature Over 100.4°F		Treated with Antibiotics	
Cryostat	8.8 days	22 (40) pts.	55%	16 (40) pts.	40%
Control	10.2 days	30 (40) pts.	75%	31 (40) pts.	78%

* *Total Days Admission to Discharge*

Table 3: Comparison of Operative Procedures in Cryostat and Control Groups

Treatment	CRYOSTAT Positive	CRYOSTAT Negative	ROUTINE CONE Positive	ROUTINE CONE Negative
None	0	3	1	2
T.V.H.* with Cuff	11	6	4	1
T.A.H.** with Cuff	13	4	25	6
Radiation	3	0	1	0
Total	27	13	31	9

* *T.V.H.—Total vaginal hysterectomy*
** *T.A.H.—Total abdominal hysterectomy*

Discussion

From the accumulated data, it is obvious that the cryostat conization procedure has several advantages over the standard procedure. Hospital stay and the need for antibiotic treatment are decreased substantially. Since a quicker diagnosis can now be made, the physician can proceed with a diagnostic cone in cases of atypia, whereas in the past he may have performed a hysterectomy without this intervening procedure. In addition, with this method, only one anesthetic is needed, the possibility of further blood loss from the cervix in the interval between cone and hysterectomy is precluded, and the anxiety of the patient is alleviated greatly, knowing that if she does have carcinoma of the cervix immediate treatment will be given without further delay. Also, the physician must no longer schedule two operations, and postoperative morbidity is reduced since the physician operates through a clean wound rather than an infested area (after eight hours).

This study corroborates other reports and, on the basis of these results, the cryostat cone is now a routine procedure in selected cases at The Johns Hopkins Hospital.

Summary

Forty cases employing the cryostat section for rapid evaluation of the conization biopsy are presented. Compared to forty control cases studied in the routine manner in which the permanent sections are reviewed in 24 to 48 hours and the patient is subjected thereby to two anesthesias, the cryostat group had a lower morbidity and shorter hospitalization. Quality of sections and accuracy of diagnosis was equal in the two groups and compared favorably to several cited series. Several advantages, both theoretical and practical, have also been noted.

REFERENCES

1. VillaSanta, U., and Durkan, J. P.: Indications and complications of cold conization of the cervix. *Ob Gyn* **27**:717, 1966.
2. Rutledge, F. N. and Ibanex, M. L.: Use of the cyrostat in Gynecologic surgery. *Amer J Obstet Gynec* **83**:1208, 1962.
3. Kaufman, R. H., Abbott, J. P., and Scheihing, W. C.: Use of the refrigerated microtime for rapid diagnosis of cervical conization specimens. *Amer J Obstet Gynec* **84**:101, 1962.
4. Dutra, F. R., Clement, E. D., and Fischer, R. G.: Frozen tissue sections of uterine cervical cones in the management of patients with positive vaginal cytologic smears. *Amer J Obstet Gynec* **84**:101, 1962.
5. Guerriero, W. F., Cox, R., Tillery, W., and Race, G. J.: Clinical value of the cryostat frozen section in the diagnosis of cervical carcinoma. *Ob Gyn* **24**:61, 1964.
6. Greenberg, S. D. and Kaufman, R. H.: Use of the Cryostat in Diagnosis with frozen Sections of Specimens from Cervical Conization. *Amer J Clin Path* **40**:500, 1963.
7. Kaufman, R. H., Janes, G. O., and Cox, H. A.: Cervical conization with frozen section diagnosis. *Amer J Obstet Gynec* **92**:71, 1965.

Any case of malignant neoplasia treated with drugs, radioactive agents, or surgery should be closely followed by the physicians who administered the treatment to the patient. However, due to the need for costly equipment and specialized personnel, more women with pelvic tumors are referred to and treated in fewer medical centers which are recognized for their superior ability in handling this disease. The distance of these centers from the patient's home and the patient's advanced age and consequent poor tolerance for traveling, often prevents her from receiving this ideal medical care. Therefore, she is often treated by her family physician, who is seldom prepared and more often unwilling to cope with the complications and sequelae of cancer treatment. The following presentation will attempt to synthesize the 40 years experience in the Gynecological Oncological Clinic at the University of Maryland School of Medicine.

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Post-Treatment Care of Patients With Pelvic Malignancy

Post-Treatment Visits

In an attempt to prevent recurrence of the disease, the visits following completion of treatment include a brief history of symptoms, a physical examination, and a pelvic examination. The patient is asked questions regarding her appetite, possible increase in abdominal size, possible presence of dysuria, polyuria, or hematuria, frequency of micturition, nausea or vomiting, diarrhea, painful defecation and the presence of bloody or tarry stools, abnormal vaginal discharges or bleeding, and abdominal pains or dyspareunia. The physical examination includes weighing the patient, taking her blood pressure, examining the supraclavicular, axillary, and inguinal lymph nodes and the breasts. The abdomen is then measured for its circumference, and palpations are made of the liver and spleen, and for masses or tenderness and the presence of dullness. The lower extremities are also examined, particularly for varicosities or edema. Inspection of the vulva and perineum, speculum visualization of the cervix and vagina, sounding of the uterine cavity (if present), and bimanual and rectovaginal examinations are included in the pelvic examination. Every six months, a Papanicolaou smear is taken.

Hemoglobin and hematocrit are measured every six months, and more often if required. Chest X-ray and intravenous pyelogram are repeated six months after treatment and at yearly intervals thereafter. Other

procedures include taking biopsies of different lesions when indicated, and performing proctoscopies, cystoscopies, and different diagnostic radiologic or chemical examinations if necessary.

After completion of treatment, the patient is asked to return to the clinic every month during the first year, every two months during the second year, and so on until a maximum interval of every six months is reached. Although an attempt was made to examine patients at yearly intervals, a large number of patients failed to return, and the patient-physician relationship was interrupted. However, patients are seen more frequently if their conditions require medical attention.

Recurrence of Pelvic Malignancies

Pelvic malignancy recurs more often in the first three years following treatment (Table 1), but late recurrence (after five years) represents 3% to 6% of all recurring cases. A breakdown of late recurrences (Table 2) shows that they sometimes occur even after an interval of 33 years.

Table 1: Interval Between Treatment and Recurrence

	Carcinoma of Cervix	Carcinoma of Ovary	Carcinoma of Vulva
0-12 months	62%	66%	48%
13-24 months	18%	18%	21%
25-36 months	11%	3%	20%
37-48 months	5%	5%	3%
49-60 months	1%	2%	2%
> 60 months	3%	6%	6%

Table 2: Late Recurrence of Carcinoma

Number of Patients	Years after Primary Treatment
10	6
4	7
2	8
3	9
1	10
2	11
2	12
1	13
1	16
1	33
TOTAL 27	MEAN 9.2 MODE 6.8

(15 Cervix—6 Ovary—3 Vulva—3 Endometrium)

If the recurrence is recognized early enough, it can be successfully treated, as demonstrated by Brunschwig,[1] Roddick,[2] and Rutledge.[3] There are now several patients in the University of Maryland clinic who have survived longer than five years after treatment of recurrence (Table 3). Because of the very large tumor dose delivered at the time of primary irradiation, the surrounding tissues have a poor tolerance for additional radiation therapy for treatment of recurrence. Therefore, only surgery can be satisfactorily employed for treatment of recurrent malignancies.

Table 3: Carcinoma of Cervix

Mean Survival After Recurrence

Form of Treatment	Number of Patients			Months
None	219			7
Irradiation	23			18+
Surgery	35	23 Dead	13	24.5+
		12 Alive	46+	

It must be remembered that there is the tendency for several organs of the "sexual skin"[4] to be affected by squamous cell carcinoma. Several such cases have been observed with multiple regional malignancies (Table 4), probably due to persistence of the same stimulus acting on similar stratified squamous epithelium. Whether this is due to recurrent disease, residual disease at the margin of resection, or to a multicentric origin of the tumor is still debatable. The concept of "cancerization" of normal tissue, first proposed by Brunschwig and Tschetter[5] for carcinoma of the skin, has been reintroduced by Woodruff and Williams[6] for lesions of the cervix, vulva, and vagina. Also in cases such as these, prompt treatment of the second or third malignancy can be highly successful.

Any patient with one malignancy has a tendency to develop a second one in an unrelated organ, as shown in Table 5. In the University of Maryland clinic, approximately 5% (49) of the 1,000 patients whose cases were followed for five years or longer developed second and third malignancies. A similar incidence was reported by Day,[7] Moertel, Dockerty, and Baggenstoss,[8] Julian and Woodruff,[9] and Ostergard and Morton.[10] This figure is 20 times higher than for the normal population (50 per 100,000 annual cases).[11]

Table 4: Multiple Regional Malignancies

1.	1929 Cervix	1942 Vagina	....	1962 Dead of ASCVD*
2.	1939 Cervix	1951 Vagina	....	1968 Alive
3.	1943 Cervix	1957 Vagina	1960 Vulva	1968 Alive
4.	1946 Cervix	1954 Vulva	....	1959 Dead of Cancer
5.	1948 Cervix	1961 Vulva	1964 Vagina	1968 Alive
6.	1953 Cervix	1965 Vulva	....	1968 Alive
7.	1957 Cervix	1964 Vulva	....	1968 Alive

*Arteriosclerotic Cardiovascular Disease

Table 5: Multiple Subsequent Malignancies

Primary		Second Malignancy	Interval in Years
Carcinoma of cervix	4	Breast	1-5-7-16
	3	Stomach	3-5-5
	1	Ovary	17
	1	Esophagus	12
	3	Lung	5-13-14
	3	Rectum	12-22-27
	1	Ureter	21
	1	Bladder	31
	1	Colon	4
	2	Sigmoid	8-29
	1	Lymphoma	5
	2	Cholecystis	15-24
	1	Mediastinum	10
	3	Endometrium	12-21-27
Corpus Uteri	1	Colon	6
	1	Stomach	7
	1	Bladder	3
	1	Rectum	3
	1	Fibrosarcoma Abd. Wall	3
Ovary	2	Breast	1-4
Breast	3	Uterus	1-4-10
	4	Cervix	1-3-11-13
	1	Vulva	1
Rectum	1	Cervix	5
Thyroid	1	Ovary	1

Diagnosis and Treatment of Complications

Another reason for frequent examinations is the diagnosis and treatment of complications that frequently occur following therapy. Table 6 shows the most common complications occurring after radiotherapy for carcinoma of the cervix. It is evident that with the employment of the newer machines capable of delivering a higher and more lethal dose to the tumor, even the normal tissues suffer additional injury. One of the most common and tedious complications of irradiation is certainly the cervical-vaginal necrosis, which occurs most often six to nine months after therapy. It is characterized by vaginal discharges, often bloody, and pelvic pains or dyspareunia. This condition is very difficult to treat since there is no specific drug that can be prescribed. The necrosis requires six months to a year to heal, if it heals at all. But more often it develops into parametritis or pelvic cellulitis and frequently progresses to rectovaginal or vesicovaginal fistula. Drugs such as synthetic estrogen, thyroid extract, cortisone, etc. have been prescribed, but with no definite success. The most frequently used methods of combating the infection are local or systemic antibiotics, antiseptic douches, and, with best results, complete bed rest in the hospital. The necrosis will often produce massive hemorrhage which may become so severe that it causes the death of the patient despite attempted surgical procedures (ligation of uterine or hypogastric arteries, exenteration, etc.) and blood replacement.

Proctitis is also frequent, and usually occurs six to twelve months after irradiation. Common symptoms

Table 6: Carcinoma of Cervix Complications

	1945-55	1956-62
Hemorrhagic cystitis	9	22
Vesico-vaginal fistula	...	3
Uretero-vaginal fistula	2	...
Ureteral stenosis	...	10
Vaginal necrosis	1	42
Parametritis	3	26
Pyometra	1	2
Vesico-rectal fistula	...	1
Proctitis	22	20
Rectal stenosis	2	2
Recto-vaginal fistula	6	11
Intestinal obstruction	1	2
Thrombophlebitis	3	...
Hemorrhage requiring transfusion	...	9
Total Complications	50	150
Total Patients Treated	271	232

are tenesmus, pain, and rectal bleeding. This condition often progresses to severe rectal stenosis and requires colostomy. The most effective treatment is a low residue diet and the use of cortisone, either in the form of suppositories or injection. Proctitis sometimes progresses to rectovaginal fistula. Attempted surgery to correct this condition is seldom successful, due to the poor vascularization of the surrounding tissues, and these patients will also require a colostomy.

Another common complication is hemorrhagic cystitis, which can produce enough intravesical clots to prevent micturition. Other symptoms of this condition are hematuria, tenesmus, frequent micturition, and nocturia. Antibiotics and antispasmodics are successful in treating the milder cases, while the more severe cases require intravesical instillation of mild caustics, such as 30 cc of 0.5% $AgNo_3$ for five-minute intervals. Urinary diversion is performed only as a last resort. Most cases of hemorrhagic cystitis occur two years after treatment, but it can occur at almost any time. Sometimes it may lead to vesicovaginal fistula.

Periureteral fibrosis, causing stricture of the pelvic ureter with consequent hydronephrosis and poorly functioning kidney, is a complication not recognized until recently.[12] As a matter of fact, the presence of a non-functioning kidney in a patient with pelvic malignancy, with normal urinary function prior to treatment, was always regarded as factual evidence of recurrent carcinoma. However, in 1934 Bugbee [13] had found no cancer in four of eight patients with ureteral obstruction following radium implantation into the cervix; similar findings were confirmed by Howes and Strauss [14] in autopsies of irradiated patients who died of hydronephrosis or pyelonephritis. Ten cases of periureteral fibrosis have been observed at different times, most of them between 21 to 30 months following treatment. If the stricture is discovered promptly, the kidney can be salvaged by a diversion. Reimplantation of the ureters in the bladder is not feasible, because of the poor vascularity of the pelvic tissues

and the wide space to fill. Ureteral dilatation has not been attempted.

Intestinal obstruction due to postoperative adhesions, radiation peritonitis, or metastatic mesenteric malignancy is also frequently observed in these patients. Should medical management such as suction and parenteral feeding fail to relieve the obstruction, surgical exploration and resection or colostomy are mandatory. Intestinal obstruction and various forms of urinary and fecal fistulas often follow radical surgery and may require several surgical corrections.

Psychological Management of the Patient

Another important facet to consider is the psychological management of pelvic malignancy patients. First of all, should the patient be told that she has a malignancy? Experience has shown that the great majority of patients will accept the facts as a relief from fear and doubt. Most patients already suspect the truth. But the seriousness of the disease should be underplayed. The doctor should always be optimistic: "Almost 20% of the patients recover," rather than "Over 80% will die". The necessity of life-long follow-up programs from the beginning of treatment should be stressed, and the patient will usually accept this. The follow-up examination should be made as pleasant and painless as possible, so that the patient will not dread her next appointment. Every step of the examination should be explained in order to reduce additional fear. The five-year follow-up program in this clinic contained 95.4% of the original patients, most of them from the lowest socioeconomic classes. This is valid proof that even better results can and should be achieved in private practice.

A common observation is that if the patient has someone to talk to her or call her if she misses an appointment, etc., she will more readily respond to any diagnostic and therapeutic measure designed to cure her disease. The busy practitioner should allow sufficient time for adequate examination of cancer patients. Perhaps he should schedule one session a week or month, according to the number of patients he is treating, solely for the examination and treatment of this group of patients. Often a patient will receive beneficial group psychotherapy in the waiting room.

Such patients should be advised to return to normal life and possibly to their previous occupation as soon as possible, even if on a part-time basis. Sexual activity should be resumed after surgical incisions have healed (usually six to eight weeks) and one to two weeks after internal radium therapy. After surgical or actinic castration, substitutional therapy should be given in the form of synthetic estrogen to prevent menopausal symptoms, dyspareunia, osteoporosis, and cardiovascular changes. The diet should be adjusted to the patient's need. Iron and vitamin additives stimulate the appetite and speed up the postoperative recovery: they should also be prescribed. Certainly a physically and emotionally well-adjusted patient is a worthy reward for the physician's effort.

REFERENCES

1. Brunschwig, A.: What are the Indications and Results of Pelvic Exenteration? *JAMA* **194**:274, 1965.
2. Roddick, J. W. Jr., and Miller, D. H.: Factors Affecting the Management of Recurrent Cervical Carcinoma, *Am J Obst & Gynec* **101**:53, May 1, 1968.
3. Rutledge, F. N., and Burns, B. C.: Pelvic Exenteration, *Am J Obst & Gynec* **91**:692, 1965.
4. Newman, W., and Cromer, J. K.: The Multicentric Origin of Carcinomas of the Female Anogenital Tract, *Surg Gynec & Obst* **108**:273, 1959.
5. Brunschwig, A., and Tschetter, D.: The Mode of Inception and Lateral Spread of Certain Squamous Cell Carcinoma, *Surg Gynec & Obst* **67**:715, 1938.
6. Woodruff, J. D., and Williams, T. J.: Multiple Sites of Anaplasia in the Lower Genital Tract, *Am J Obst & Gynec* **85**:724, 1963.
7. Day, J. C.: The Second Primary Malignant Tumor in Gynecology, *Am J Obst & Gynec* **75**:976, 1958.
8. Moertel, C. G.; Dockerty, M. B.; and Baggenstoss, A. H.: Multiple Primary Malignant Neoplasms, *Cancer* **14**:221, 1961.
9. Julian, C. G., and Woodruff, J. D.: Multiple Anaplasias in the Lower Genital Canal, *Am J Obst & Gynec* **95**:681, July 1, 1966.
10. Ostergard, D. R., and Morton, D. G.: Multifocal Carcinoma of the Female Genitals, *Am J Obst & Gynec* **99**:1006, December 1, 1967.
11. Ferber, B., et al: Cancer in New York State, Exclusive of New York City, 1941-1960. A Review of Incidence, Mortality, Probability, and Survivorship, 1962.
12. Kirchoff, H.: Komplikationsreiche Veranderungen am Harnsystem nach Strahlentherapie des Kollumkarzinoms, *Geburtsh u Frauenh*, **20**:34, 1960.
13. Bugbee, H. G.: Ureteral Occlusion Following Radium Implantation into Cervix, *J Urol* **32**:439, 1934.
14. Howes, W. E., and Strauss, H.: The Significance of Urological Surveys in Cervical Carcinoma, *Am J Roentg* **41**:63, 1939.

Medicare and Nursing Homes:

The Changing Scene

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I will discuss some current issues concerning medical care which have special relevance to the Medicare program and particular interest for professionals who are active in the skilled nursing home field. What I propose to do is to review some of the more pressing problem areas affecting medical care of the aged, especially medical care in long-term facilities. A heightened awareness of these problems and the resolution to do something about them characterize the changing scene which is accompanying a new and vigorous administrative thrust toward improving and tightening up the administration of the Medicare program.

The Cost of Medical Care Services

Medical care costs and medical care prices are among the most pervasive problems on the current medical care scene. They are by no means confined to the services which aged persons receive. While care of the aged in nursing homes, hospitals, and physicians' offices has received much recent publicity, attention must be paid to the total costs, the prices, and the expenditure problems for the entire population. Since the medical care dollar is not a limitless resource, we will have to consider very carefully how we order massive expenditures for health care and how we allocate the money, manpower, and facilities which make this care a reality.

Certainly the growing problem of medical care costs and prices suggests that some decisions will have to be faced, and soon. There is little doubt that the Medicare system is not entirely within our control. It might be a good idea to look at a few facts and to examine a few apparent trends which will form the basis for future decisions. A brief examination of hospital and physicians' charges shows:

(1) Daily service charges for hospitals have increased faster than any other component of the medical care price index. From 1946 to 1960, daily service charges increased at an annual rate of 8.3%; from 1960 to 1965, the rate was 6.3%; but in 1967—a single year, the rate increased to 19.1%, although in 1968 it dropped to a not inconsiderable 13.2%.

(2) The demand for higher wages is the major factor in the rising price of institutional care. While wages have been low, the considerable gains which have been achieved recently have not necessarily resulted in higher labor productivity. Unfortunately, machines are simply incapable of providing medical care, especially therapeutic care. The need for the human component in the medical care system is quite unlike the situation which prevails in the typical American industrial organization.

(3) Though physicians are the major focus of the increasing demand for medical care services which has developed out of improved insurance coverage, public programs such as Medicare and Medicaid, and a growing awareness of the value of medical care, the supply of physicians has not kept pace with the demand. Nor have the methods of providing or delivering care greatly relieved the present situation. In plain economic terms, increase in demand usually results in increased prices for the services required. Physicians' services, which have not increased sufficiently, are no exception.

A brief examination of some significant trends in medical care expenditures may be useful at this point.

(1) The institutional resources in this country include some 20,000 long-term care facilities. These facilities contain approximately 900,000 beds. About one half of the patients in nursing homes receive their care through payments from public agencies under the Medicare and Medicaid programs. For fiscal 1968, federal, state, and local funding agencies spent almost $1 billion for nursing-home care under the

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Medicaid program. This amounted to 30% of all the expenditures made for medical assistance during that period. In addition, Medicare paid out $330 million to extended-care facilities.

(2) The average extended-care facility claim has risen sharply since the ECF program began under Medicare. During its first year, 1967, the average claim was $306. However, the average for all ECF claims, through October 1968, was $368.

(3) Medicare expenditures amounted to $3.4 billion in fiscal 1967. They are expected to reach $6.8 billion by fiscal 1970. Medicare hospital insurance expenditures alone—which include extended-care facility billings—will reach over $5 billion by that year, and medical insurance expenditures (the Part B of the Medicare program) will make up the balance. From July 1966, when Medicare began, until October 1968, the Social Security Administration paid out $6.85 billion against some 15 million Medicare claims.

(4) During fiscal 1968, $53.1 billion was spent on health care in this country. Medicare's share was $5.3 billion, about 10% of that total figure. Total public expenditures amounted to $19.4 billion, and Medicare's contribution exceeded one fourth of that total. Some interesting shifts in sources of payments have occurred. For example, in the year preceding Medicare, about 69% of the payments for personal health care of the aged came from private sources. In the first year of Medicare, fiscal 1967, the private sector's share dropped to 41%. In that same year, over one third of the financing of medical care for the aged which came from public sources was paid by Medicare.

(5) Hospital expenditures reflect similar shifts in source of expenditures. Per capita hospital care expenditures for the aged during fiscal 1966 came to $182. Of this figure, $93 was supplied from the private purse. In the following year, fiscal 1967, the aged person's hospital bill rose to $222, but only $18 came from the private purse. Fully three fifths of the public share of $204 came from Medicare.

(6) Per capita private expenditures for physicians' services to aged persons amounted to $66 in 1966, the year before Medicare. In 1967, that figure dropped to $46 at the same time that the public's share rose from $5 in 1966 to $39 per capita in 1967. Included in those figures are the $3 monthly premiums that were paid by, or in behalf of the aged person. Altogether, Medicare paid $626 million to physicians for services to aged persons during Medicare's first full year. This amounted to 39% of the total bill for physicians' services to the aged of $1.6 billion for the year.

So much for illustrative data. The above statistics have been used to underline some of the sources of growing public concern over the costs of medical care. The changing scene suggests that the Administration is responding to this concern. The efficient, economical operation of health related programs is one form of response, but in addition, the Administration has taken specific steps to moderate the rising costs of health care. It was felt that cost finding in institutional settings had become much more precise than it had been in the beginning. Reasonable costs for institutional care have become more familiar entities, in other words, and any "extra" amounts to cover "unknown" items seem to be no longer necessary. Accordingly, the decision was made to eliminate the 2% extra payment in addition to audited costs to not-for-profit facilities and 1½% payment to proprietary establishments under Medicaid and Medicare. The American Hospital Association has reported growth in hospital income under Medicare, and certainly private investment has become increasingly attracted to the nursing home field. The changing scene suggests that the "cushion" which was built into the 2% and the 1½% extra should be replaced by the development of more efficient ways of meeting costs, and in fact, reducing costs, without affecting the quality of care.

Vital Statistics on Aging Americans

I would like to turn now to numbers with a different significance than the figures we have just reviewed. I am referring to some rather familiar statistics which describe our 20 million older Americans, numbers which yield the facts of life and death about our aging population. Somehow, the meaning of these numbers escapes us from time to time and we fail on occasion to draw appropriate implications from them.

Older Americans represent not only a growing number but a growing force which is changing the distribution of the nation's health care resources necessary to meet its demands and their attendant costs. A changing scene shows that very soon we will have to decide, in some coordinated way, just how we propose to deal more effectively with the complex demands of this group, how we will allocate our stock of resources, order expenditures, and structure services.

A brief review of the statistics may place the problem in focus.

(1) Although at the present time about one person in ten in this country is 65 years of age or older, the characteristics of these 20 million people and the implications for the future are not clearly understood. Within five years, for

example, there will be a net increase of 1½ million older persons, but one third of this number will be complete newcomers to the group—with different and changing cultural, social, and economic backgrounds and rather different needs and demands. By 1990, it is anticipated that the total will reach 27 million —a larger, somewhat different population than we have today.

(2) Of the 20 million older persons, 37% are 75 years of age or older. There are more than one million people who are 85 years of age or older. In addition, for every 134 older women there are 100 older men, and life expectancy continues to increase faster for females than for males. Among the elderly, there are four times as many widows as widowers.

(3) Only 48% of the elderly live in family groups in which both husband and wife are still present. While only 5% are living in institutions, a full 25% live alone or with nonrelatives. Some experts feel that the increasing trend toward living outside the family group presages further needs by the aged for eventual institutional living with related changes in the structure of their medical care services.

(4) As an older population increases at a rapid rate (50.1% from 1960 to 1985) the prevalence of chronic illness will grow even more rapidly as the population ages. It is estimated that by 1985, there will be 6½ million more people with chronic illness than there were in 1960.

These are impressive figures. Nursing homes and the duties of their staffs are going to be affected by the pressure of these statistics and their very special impact on the health care system. Obviously, we cannot reduce the aged population, so we will have to decide how to deal with it more effectively, how to minimize some of the deteriorating effects of growing old, and how to begin to balance the nation's resources against the needs of the aged and other population groups as well.

More Nursing Homes and Nursing-Home Beds

The recent increase in the building of nursing and related care homes is one obvious response to the increased demand for medical care services. Federal legislation, and particularly legislation affecting reimbursement, has provided the major impetus. The obvious result has been more beds, more health care personnel and, in general, more quality service in nursing care and related homes. This growth pattern presents a number of questions. How many more nursing home beds do we really need? Can we afford all of them? And of what type should they be? Will the present form of nursing-home care and organization continue to meet the needs of the elderly? Are we giving sufficient attention to institutionally based centers for ambulatory and outpatient services? What can we anticipate regarding the impact of rapidly expanding corporate involvement in nursing home organization, particularly on costs?

At this point, we might review very briefly some basic nursing home statistics which will help us understand patterns of growth and change. We have had some reasonably useful nursing home statistics since 1939, when the Census Bureau reported some 1,200 nursing care, convalescent, and rest homes in this country with a total of 25,000 beds. By 1954, those figures had changed, in a Public Health Service count, to 25,000 homes and 450,000 beds. In 1967, a somewhat more discriminating counting process reported 20,000 nursing and personal care establishments. At any rate, from 1963 to 1967, the number of beds in nursing care and related homes increased by about 50%, from a total of 568,000 to 846,000. Sixty-nine percent of the 1967 total were nursing care beds, pretty much as we would define them today. While I do not have currently updated figures at hand, the process of adding more beds (and filling them) goes on.

But the real question is whether or not, despite this growth, we have a sufficient supply of nursing home beds. I don't think we really know, though we do have some doubts about their distribution, and within the Medicare program, at least, whether or not we are using extended-care facility beds effectively. The following figures should illustrate this point. As of July 1968, some 4,700 extended-care facilities were participating in the Medicare program. They contained a total of 330,000 beds. In that year, 13% more *facilities* were added to the program, with 54% of the increase occurring in the Pacific, East North Central, and Middle Atlantic regions alone. Extended-care facility *beds* increased by 13% also, about 38,000 beds. One quarter of the increase occurred in the Pacific states, while the Middle Atlantic and East North Central states claimed 31% of the total. On the other hand, despite a gain over 1967, the change in East South Central states was only from 9.5 extended-care facility beds for every 1,000 Medicare beneficiaries to 11.8/1,000 in 1968. The national distribution rate reached 17.2/1,000 by July 1968. In comparison, New England states reported 20.1 beds/1,000, the West South Central region 25.4/1,000, and the Mountain states reported 33.9 beds.

Do these figures suggest some inequity of distribution? Mr. Arthur E. Hess, Deputy Commissioner of the Social Security Administration, in a recent presentation before a meeting of nursing home principals, indicated that we were probably overbuilt in some areas but that there was a long way to go before we could report accessible services in all the remote communities, and in some growing population centers

of the country. The changing scene suggests a much more thorough examination of the distribution and utilization of nursing home facilities under the Medicare program.

Administrative Problems

We should anticipate some new and definitive approaches to a number of administrative problems related to extended-care facilities under the Medicare program. These problems are rather clearly delineated and their resolution is certainly part of the changing scene. First, the ever-present problem of utilization review is still a weak point in the program. Second, concern over levels of care which patients are receiving in ECF's continues, but there is increasingly effective determination of this issue. Actually, the question is whether or not that level of care is covered under Medicare's ECF benefits. And third, problems have arisen with some institutions where ancillary services under arrangements with outside organizations may be exceeding reasonable costs.

A good deal of the present difficulty may be due to an apparent misunderstanding over the basic provisions of the Medicare law which provides for ECF care as an extension of hospital care, on a short-term basis and with skilled nursing care emphasis. Utilization committee experience is under careful review now, not only within ECF's but among hospitals as well. More careful decisions regarding the necessity for extended care, while the patient is still in the hospital, will simplify medical care coverage questions when the patient is admitted to the ECF. ECF utilization review practices are also under study. It would seem advisable for extended-care facilities to carry out utilization review more frequently in order to avoid possible denials of Medicare claims. Sample review of professional and administrative practice within extended-care facilities requires greater encouragement as well, for it is from the recorded experience of the care of the patient that medical directors of institutions and program administrators alike can determine what improvements may be necessary.

Incentive Reimbursement Experiments

Late in 1967, the amendments to the Social Security Act included a provision authorizing the Secretary of the Department of Health, Education and Welfare to experiment with various methods of reimbursement. The purpose of this experimentation was to create new incentives to provide efficient and economical medical care services. Congress clearly intended that the Department should turn to nongovernmental agencies and institutions for experimental innovations in the reimbursement process and an examination of the history and discussions concerning this provision certainly supports this recommendation. To date, the nongovernmental sector has not been overly responsive so that relatively few useful proposals have been submitted to the Department despite a very considerable effort to attract proposals from hospital and nursing home groups. As costs continue to rise and as public concern over the phenomenon continues to grow, the need for innovative approaches is more apparent than ever. The absence of a substantial number of proposals raises some interesting questions. Can't the traditional method of reimbursing for hospital and nursing home costs yield any improvements in efficiency or economy of operation? Will it be necessary, through the legislative process, to select some alternative methods of payment? The Administration wants to exploit the possibilities of an incentive approach to minimizing hospital and nursing home costs to the fullest, and incentive reimbursement is a lively issue at the present time. The medical care institutions are urged to join in efforts to consider experimentation proposals.

Conclusion

The Administration is keenly aware of the real dimensions of the changing scene in health care in this country. It has underscored the urgent need for concerted action by government and the private sector in dealing with the problems in health services delivery and their vital connective systems. The Secretary noted very recently that we tend to be overusing high-cost, acute-care facilities while the increasing need is for lower-cost alternatives. Certainly the role of the skilled nursing home as one of those lower-cost alternatives has yet to be fully realized. Is it continuing to be, as Congress intended, and as the nation's health care system really requires, an extended-care facility, or is it something else? If nursing homes can be extended-care facilities, to what extent are their admissions limited to the elderly Medicare or Medicaid beneficiaries? To what extent are younger hospital patients being admitted to nursing homes for post-hospital, post-acute, moderate cost institutional care? These are only a few questions of immediate interest for the physician in a nursing home or a chronic disease facility.

The primary concern is for the efficient administration of a comprehensive series of legislatively authorized medical services for the aged. Problems of administrative management are increasingly problems of cost management and cost containment. Seen in this way, it should be clear that decisions about program costs must be made continuously. No one seems to question the general need for medical care services, but within the framework of the law and our stock of resources, there are serious questions about how we shall afford them.

The solutions to the problems which this discussion has posed will take many forms. Because health care services are changing now, and are likely to change their traditional character even more tomorrow, we can't really predict what forms they will take, but the likelihood is that these changes will evolve out of experience, experimentation, and out of needs and demands which are also changing.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on February 12, 1970, and took the following actions:

1. Approved the proposed revised State Department of Health and Mental Hygiene Radiation Control regulations;
2. Adopted the Special House of Delegates minutes for December 13, 1969;
3. Approved the annual $100 contribution to the Student American Medical Association;
4. Agreed to recommend to the Council that the three-year contract of the Executive Secretary be renewed for a similar term and under the same conditions as previously. This is in accordance with Article VII, Section 5 of the Faculty Bylaws;
5. Appointed the Executive Secretary and Watson P. Kime, MD, as Delegate and Alternate to a "working group" of the State Comprehensive Health Planning Agency;
6. Declined to participate in a proposal to develop a uniform hospital abstract discharge summary, inasmuch as there are other means to accomplish the same objectives which should be explored first;
7. Designated nominees for the Board of Physical Therapy Examiners for appointment by the Governor;
8. Agreed to attempt to set up within the law a provision for a Medical Advisory Group in the legislation establishing a new Department of Transportation within State Government;
9. Declined to release data to a physician from Mediation Committee files because it is Faculty policy not to release data of any kind from its files;
10. Discussed with the Journal Editor the financial status of the Journal and adopted various recommendations to be made to the Council;
11. Agreed to join as Amicus Curiae in connection with a trial in the Court of Appeals dealing with a patient's right to reveal information as to his condition to a physician and to have this information used to convict him in court;
12. Heard briefly about the "arbitration panel" to arbitrate malpractice actions which is currently being considered in the Medical Economics Committee; and also heard that legal counsel had requested the Court to establish a Rule of Procedure that would require posting of a $500.00 bond to cover costs in any malpractice actions filed with the Court;
13. Rereferred to the Council proposals of Prince George's County Medical Society that would (a) provide for trial by judge or jury at option of defendant in Tort cases, and (b) attempt to outlaw the "contingent" fee in legal fees;
14. Referred to the Policy and Planning Committee the AMA proposals on long-range planning with a request that a report be made to the Council prior to the June 1970, AMA House of Delegates session.

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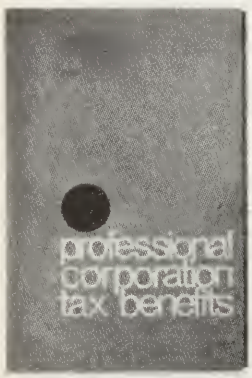
The Executive Committee met jointly with the Hospital Council Executive Committee later the same day to discuss:

1. The proposed arbitration panel for malpractice actions;
2. Verification by hospitals of house staff physicians' credentials and possible illegal use of unlicensed physicians in hospitals outside of training programs;
3. Legislation currently pending and proposed for the future in the General Assembly at Annapolis.

Should You Incorporate?

Maybe Yes.

The present I.R.S. position boils down to this: When you become an employee of your own professional corporation or association, a lot of good things can happen. For one thing, you may cut your income tax. For another, you can beef up your retirement investments with more tax-sheltered dollars.

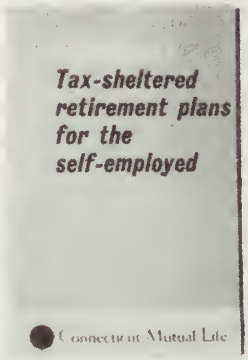


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Charles County—Annual Election: December

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La Plata, Maryland 20646

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Dorchester County—Annual Election: November

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East New Market, Maryland 21631

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Frederick County—Annual Election: December

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Frederick Medical Center
800 Toll House Avenue
Frederick, Maryland 21701

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Parkview Medical Center
516 Trail Avenue
Frederick, Maryland 21701

Edward Koenigsberg, MD, Secretary
801 Toll House Avenue
Frederick, Maryland 21701

Mrs. Rose M. Willard, Executive Secretary
Frederick Medical Center
Frederick, Maryland 21701

Harford County—Annual Election: December

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Howard County—Annual Election: December

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Ellicott City, Maryland 21043

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Kent County—Annual Election: December

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216 High Street
Chestertown, Maryland 21620

John S. Green, III, MD, Secretary-Treasurer
Kent & Queen Anne's Hospital
Chestertown, Maryland 21620

Montgomery County—Annual Election: December

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Bethesda, Maryland 20014

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Prince George's County—Annual Election: December

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Riverdale, Maryland 20840

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St. Mary's County—Annual Election: January

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Mechanicsville, Maryland 20659

Abdussamid Samadi, MD, Vice-President
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Eugene Guazzo, MD, Secretary-Treasurer
Mechanicsville, Maryland 20659

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Hagerstown, Maryland 21740

Sidney Novenstein, MD, Vice-President
Funkstown, Maryland 21734

Ralph H. Williams, MD, Secretary
Department of Radiology
Washington County Hospital
Hagerstown, Maryland 21740

Miss Doris V. Wooden, Executive Secretary
Washington County Hospital
Hagerstown, Maryland 21740

Wicomico County—Annual Election: December

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Medical Center
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209 Maryland Avenue
Salisbury, Maryland 21801

Mrs. Dorothy Holland, Executive Secretary
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Worcester County—Annual Election: October

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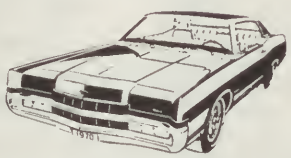
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tuberculosis

Tuberculous Peritonitis

Percutaneous biopsy of the peritoneum was a simple and quick method of diagnosing tuberculous peritonitis in 47 patients. The condition was successfully treated with antituberculosis drugs. Addition of a steroid improved long-term results.

Forty-seven patients with tuberculous peritonitis were followed for periods ranging from two to almost six years. The purpose was to ascertain how frequently such patients have tuberculous foci in the lung, intestine, or fallopian tube.

It was also intended to test the usefulness of histologic techniques for the diagnosis of peritoneal tuberculosis, and to find out whether the involvement of other serous membranes such as the pleura and pericardium occurred often in tuberculous peritonitis. Effectiveness of antituberculosis drugs and the role of adrenocorticosteroids in the treatment of this condition were also evaluated.

Of the 47 patients, 20 were men and 27 were women. All had been admitted to a medical ward of the Irwin Hospital in New Delhi, India, between 1963 and 1966.

In each case, diagnosis was based on the finding of a caseating granuloma in a biopsy specimen of the peritoneum. Other studies included X-ray examination of the chest, tuberculin skin tests, and, in the case of the women, salpingograms.

All patients had fever and ascites. Other clinical manifestations included abdominal pain, often only vaguely described and vaguely localized, night sweats, anorexia, and weight loss. Before admission, symptoms had been present from two weeks to seven months. The average was three months. Total white-cell count in the peripheral blood was within normal range in 86% of the patients and mildly elevated in the remaining 14%. Hemoglobin values were between 10.0 gm and 13.0 gm per 100 ml.

None of the patients had ascitic fluid protein content below 3.0 gm per 100 ml. The highest value was 7.5 gm per 100 ml. Pleocytosis in ascitic fluid ranged between 150 and 2800 leukocytes per cubic millimeter. Lymphocytes accounted for 75% to 96% of the total cell count. The tuberculin test was positive to first strength PPD in all cases.

Lung Focus Rare

Only three of the patients showed a focus of infection in the lung on X-ray film. Barium studies to detect intestinal tuberculosis showed increased intestinal motility and dilatation of segments of small bowel in 24 (51%) patients, but in no patient was an intrinsic intestinal lesion detected. Intravenous pyelography did not reveal renal abnormality in any of the patients, and salpingography in the women gave no evidence of a lesion in the fallopian tubes. On direct smear examination of ascitic fluid, acid-fast bacilli were found only once. Cultures, however, were positive in 39 cases.

Because of the time necessary to culture the bacilli, an evaluation of various techniques for histologic diagnosis was made.

Biopsy Procedure

Percutaneous liver biopsy was not found to be helpful. Percutaneous biopsy of the peritoneum, with the use of an Abrams needle first and a Cope needle later in the study, was tried in all 47 patients. A caseating granuloma in the biopsy specimen was demonstrated in 30 (64%) of the patients. In the remaining 17 patients, peritoneoscopy was carried out. With the addition of this procedure, the success of histologic diagnosis rose to 85%. In the remain-

MADAN M. SINGH, MD; AMAR N. BRARGAVE, MD; and KRANTI P. JAIN, MD. *The New England Journal of Medicine,* November 13, 1969 (Vol. 281, No. 20).

ing seven patients, laparotomy was necessary to obtain histologic diagnosis. At laparotomy, the peritoneum was found to be studded with tubercles. There was thick exudate, and loops of bowel were often badly matted together.

On X-ray examination, 15 patients were found to have pleural effusion in small amounts. A diagnosis of "cryptic pericarditis" was made in six patients on the basis of electrocardiographic findings even though none had chest pain, pericardial friction rub, or radiologically enlarged hearts.

Antituberculosis drugs were administered to all patients. Streptomycin and isoniazid were first given. After three months, PAS was substituted for streptomycin. In all, the antituberculosis drugs were given for 18 months. Alternate patients also received prednisone, which was gradually tapered off during the fourth month and discontinued at the end of that month.

The antituberculosis therapy was highly effective. No deaths occurred in the patients treated. However, intestinal obstruction developed a year and a half or more later in three of the 24 patients who did not receive the steroid, and surgery was necessary. This complication was not seen in the patients who had steroids.

One of three patients with "cryptic" pericarditis who did not receive the steroid had frank manifestation of constrictive pericarditis and had to undergo surgery two and a half years later. None of three patients in the steroid-treated "cryptic" group had constrictive pericarditis. Thus, in four of the 24 patients treated without steroids, late fibrotic complications of tuberculosis developed.

The study shows that parenchymal pulmonary foci are uncommon in patients with tuberculous peritonitis, the rate in this series being only 6%. It therefore seems unreasonable to attribute tuberculous peritonitis to a hematogenous spread from a concomitant pulmonary focus in the vast majority of such patients.

Latent Tuberculous Focus?

The evidence strongly favors the hypothesis of C. M. Nice, Jr., that tuberculous peritonitis is due to the activation of a long latent tuberculous focus in the peritoneum, perhaps established years previously as a result of hematogenous spread from a primary focus in the lung. Healing of the pulmonary focus was so complete that no X-ray evidence of a lung lesion was apparent.

In the present series, percutaneous biopsy of the peritoneum was a useful method of arriving at a quick diagnosis. The success rate was high. However, the possibility of bleeding and bowel perforation must be kept in mind, and the biopsy should be performed only on patients with ascites. Patients should be followed closely for 48 hours after the procedure. If a patient's condition becomes worse, a diagnostic paracentesis must be performed rapidly to ascertain whether complications have developed.

The fact that no deaths occurred in the present series shows how effective antituberculosis drugs are in treating the condition. The study also points to the desirability of adding steroids to the antituberculosis drug regimen in treating tuberculous peritonitis.

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Maryland State department of health

Local Diagnostic and Advisory Service For Handicapped Children

Special multi-professional diagnostic services for handicapped children currently exist in 13 of Maryland's health departments.* A community program initiated in 1963—the Diagnostic and Advisory Service—was established to supplement rather than to supplant any of the already existing public and private health services. In so doing, it fulfilled a great local and state-wide need for a comprehensive diagnostic resource to evaluate multiple handicapped children and their families.

An outgrowth of the Diagnostic and Evaluation Centers for handicapped children at Johns Hopkins and University of Maryland hospitals—the Diagnostic and Advisory Service—bridges the gap in distance and communication between the metropolitan diagnostic centers and local communities where patient management actually occurs. At the present time, the Diagnostic and Advisory Service consists of two full-time and one part-time traveling team of professionals, a pediatrician, psychologist, state and local public health nurses, and social worker in some counties. Frequency of clinic visits varies from as often as twice a month in some counties, to twice a year in others.

The clinic day's work involves evaluation of only two children. However, the team typically renders a service to the whole family in which the exceptional child is the focal member. Time is allowed for careful clinical evaluations, parent counseling, and staff conferences. A conference arranged at the end of each clinic session permits team members, local health department staff, and especially other vital professionals including private physicians, educators, and social workers to confer and formulate realistic plans for handicapped children. Local specialty clinics and private physicians provide additional consultative or management services when needed. The philosophy of the service places the overall responsibility for long-term management on the community.

Children known or suspected of having one or more handicaps are considered eligible for referral to the Diagnostic and Advisory Service. Those cases referred are further screened by the team. Eligibility for service is based mainly on the type of problem rather than indigency or family income. Priority is, furthermore, given to young children of preschool age in the interest of early identification and prevention of secondary handicaps. Sources of referral to the Diagnostic and Advisory Service have typically been public health nurses, specialty clinics, private physicians, local departments of education, and social services. About two thirds of the children seen are intellectually handicapped or mentally retarded to varying degrees. The mobile team also serves as diagnostic resource in counties where day care centers for the mentally retarded also exist. In addition to known or suspected mental retardation or other types of delayed development, examples of other appropriate referrals would include children with suspected cerebral palsy, multiple physical handicaps such as cleft lip and palate, neurological dysfunction, perceptual problems, and other learning disabilities. The team is neither designed nor equipped to deal effectively with known or outright psychiatric dis-

* *Allegany, Calvert, Caroline, Cecil, Charles, Frederick, Garrett, Harford, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties.*

orders, juvenile offenders, or previously diagnosed children in need of direct treatment services.

The teams have now evaluated over 800 children with multiple handicaps, re-evaluated over 250 of these at least once, and followed the progress of countless other children by consultation. While so doing, the traveling clinics have attempted to demonstrate a holistic team approach to handicapped and retarded children emphasizing quality, coordination, and continuity of care. A continuing but unfulfilled objective of the Diagnostic and Advisory Service remains one of developing locally operated and staffed multi-diagnostic services for handicapped children in regions where interested, adequately qualified manpower is potentially available.

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Employee-Patient Ratios

The ratio of employees to patients in Maryland's four regional psychiatric hospitals (Crownsville, Eastern Shore, Springfield, and Spring Grove) has more than doubled since 1950. The following table shows that this change has been caused mainly by an increase in the number of employees. The average size of the patient population in these hospitals, which increased until 1955, has since declined below the 1950 level.

FISCAL YEAR	AUTHORIZED POSITIONS	AVERAGE SIZE OF PATIENT POPULATION	AUTHORIZED EMPLOYEES PER 100 PATIENTS
1950	1,719	7,844	21.9
1960	3,225	8,516	37.9
1964	3,553	7,821	45.4
1968	4,188	7,435	56.3
1969	4,222	7,161	59.0

This rising employee-patient ratio relates primarily to a continuing change in the patient population's composition resulting from a sevenfold increase in admissions (from 1,953 in 1950 to 13,567 in 1969) and a tenfold increase in live releases (from 1,233 in 1950 to 12,944 in 1969). In 1950, 65% of all patients had been hospitalized five years or more, 20% had been under care between one and five years, and the remaining 15% were hospitalized less than one year. These percentages are now 45, 25, and 30, respectively. Patients hospitalized for the short-term treatment of acute disturbances require much greater staff services than do chronic patients under care for extended time periods.

Latest available national statistics (for 1968) provide some indication of the relationship of employee-patient ratios to patient turnover and release rates. Arkansas, Colorado, and Nebraska (with 86.1, 133.9, and 105.8 employees per 100 patients, respectively) all had more live releases than admissions. The average size of their patient population decreased 53.3%, 62.4%, and 38.4% in the last five years. Alabama and Florida (with 29.1 and 48.2 employees per 100 patients, respectively) had more admissions than releases and were the only states with a reported patient population increase during this five-year period. Maryland, which ranked 21 in employee-patient ratios in 1963 and 24 in 1968, had a 7.4% decrease in the average size of its patient population during this period. Its four regional hospitals had more admissions than live releases.

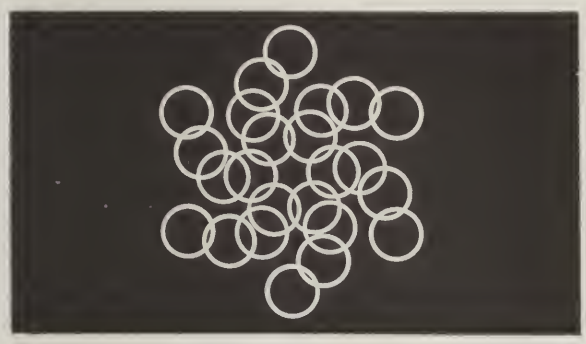
It should be recognized that data on authorized staff can be deceptive if vacant positions are not taken into account. In June 1968, 298 of the 4,222 authorized positions were unfilled so that the ratio of employees to patients was reduced from 59.0 to 54.8. Furthermore, more than five employees are required for positions which have to be filled on a 24 hours a day, seven-days-a-week basis and many staff members are not directly involved in inpatient treatment. For example, one third of the Department's psychiatrists are either engaged in an administrative capacity or in the treatment of patients on an outpatient basis. Because of these factors, many hospital areas, particularly in chronic, long-term wards, continue to have minimal employee-patient ratios.

If current programs remain unchanged, the number of admissions to these hospitals will continue to increase 10% or more per year. This would produce a gradual rise in the proportion of beds occupied by acutely ill patients receiving short-term treatment. Based on these facts, the maintenance of appropriate employee-patient ratios and the development of alternative community-centered services is imperative.



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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

The Pharmacological Approach To Alcoholism—*Part 1*

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The drug we will consider is ethyl alcohol, also commonly known as ethanol, and I want to start by orienting you as a pharmacologist would be oriented. The reason ethyl alcohol deserves special attention and has a disease associated with it called alcoholism is perhaps because it was the first of the sedatives to be discovered and it has always been used socially. Alcohol is easily available without a prescription, without a physician, and has become interwoven with the fabric of our society and our social functioning. That, I think, is the reason why alcohol, rather than one of the other sedatives, has become the basis for the title of a disease.

Alcohol is one of a group of aliphatic sedatives or soporifics which include liquid substances such as paraldehyde, solid drugs such as the barbiturates, and gases like ether and chloroform. These drugs are not narcotics, which take away pain but do not necessarily put one to sleep. The soporifics don't do anything against pain but do put one to sleep. They all belong to one group of compounds whose members possess similar pharmacological behavior. Quantitatively, there are differences in how quickly they start to act and how long they last, but they are all sedatives with the same qualitative effects. Perhaps a more correct title for this disease would actually be "sedativism." This "sedativism" is addiction to any one of the soporifics, and they are all grouped together in any good pharmacology text. What is it that they have in common? What is it that they do?

We will take one example, ethyl alcohol, and examine its properties. First of all, it is an irritant. When it is ingested, it irritates the stomach lining and increases the secretion of hydrochloric acid. Hence, lesions such as peptic ulcer, esophagitis, and diaphragmatic hernia, which are aggravated by the presence of acid, are all exacerbated by alcohol. It is also an irritant to the lower gastrointestinal tract, increasing motility and producing an outpouring of fluid, which will not infrequently cause enteritis or colitis.

In addition to its properties as an irritant, ethyl alcohol is the only drug known which is absorbed in significant amounts through the stomach lining. Thus, it will reach the blood stream faster than most other sedatives and will work sooner. Ethyl alcohol reaches measurable blood levels within 15 to 20 minutes after it is imbibed. Obviously, if you want to get a very quick blood level, you can breathe ether and it will be absorbed in a matter of seconds; indeed, there are people addicted to breathing ether, chloroform, or nitrous oxide, but these drugs are not so easily obtained.

Once alcohol reaches the blood stream, three things can happen to it. It can be excreted through the lungs (anyone who has taken a few drinks knows

Edited from transcripts of a lecture delivered February 24-25 and October 27-28, 1966, for the Alcoholism Interagency Training Project of the Community Council of Greater New York. This training program for social workers has been supported by the National Institute of Mental Health.

that others can smell alcohol on his breath). It can also be excreted through the urine. Both of these pathways take care of minimal amounts compared to the total amount of alcohol that has been ingested. Most of it is broken down to two carbon chain compounds which are the basic foodstuffs of the body. Once these have been formed, the particular food source is no longer important; the body doesn't care whether calories come from alcohol or potatoes or carrots. However, alcohol goes through an intermediate acetaldehyde step, which is important only because the body cannot tolerate aldehydes. Normally it is broken down very quickly by an enzyme called aldehyde dehydrogenase to produce acetic acid, which is innocuous and can be burned up as a foodstuff. However, there is an enzyme inhibitor known as disulfiram (Antabuse) which prevents the action of the dehydrogenase. Hence, the toxic acetaldehyde can no longer be eliminated. If an individual takes Antabuse, the enzyme inhibitor, and then drinks alcohol, he is left with the toxic acetaldehyde which will make him sick.

What determines the blood level of alcohol? The body has a limit as to how fast it is able to get rid of alcohol. The individual can metabolize about one ounce every two hours, and his blood alcohol level will remain fairly constant. When alcohol is ingested, a measurable blood level is attained within 15 to 20 minutes, reaches a peak at the end of the first hour or hour and a half, and by the end of the second hour, it starts down. The blood level reaches a normal (meaning unmeasurable) level within 12 hours. If the individual takes a very large dose, the peak will be higher and last a bit longer but the blood level will nevertheless reach zero within 24 hours. In other words, no matter how much the individual is capable of drinking at one sitting, all of the alcohol is gone from his body within 24 hours. If he has any left, he has been drinking after that first drink. If that were all there was to it, people would not be drinking alcohol socially because it would not serve any purpose. But when the alcohol blood level goes up, something happens in the brain, and that is the only reason alcohol is used.

The brain is essentially a switchboard with a large number of nerve cells (neurons) whose function is to transmit impulses from one point to another. The transmission of impulses depends on a group of biochemical events, and if you interfere with any one of these, you stop the neuron from functioning. You can stop it with a sledge hammer, with a right cross to the chin, or with a "chemical hammer"—it doesn't make any difference. If you were to use a large dose of cyanide to do this, you could permanently stop the nerve cells from working. On the other hand, ethyl alcohol will stop the cells from working, but in a reversible fashion: It will interfere with function, but the body is able to fight off the drug and repair itself. However, if you take enough, you can kill the nerves. Now I can hit you on the head with a hammer and leave you unconscious, or I can hit you on the head with a hammer and leave you dead. It's the same hammer, but it's a question of how hard I hit. So, too, with this drug ethyl alcohol. I can give enough of it to kill, or a small dose to stop only certain neurons from working. Man discovered long ago that temporarily stopping some of the neurons from working may be pleasurable.

All of the sedatives or soporifics—alcohol being only one of them—are irregular depressants of the central nervous system. By depressant, I mean a substance which diminishes or stops normal function. The sedatives are irregular, because if they depressed everything simultaneously, they would hit not only the thinking centers, not only the centers concerned with balance, but also the vital centers in the medulla which are necessary to keep the heart beating, the blood vessels contracting, and the lungs breathing. Any sedative which worked on these things evenly would be totally useless because it would kill as quickly as it would sedate. But all of the soporifics work first on the cerebrum and the cerebellum, secondly on the spinal cord, and finally on the vital centers. Hence, a little alcohol works only on the cerebrum (the individual gets a little confused or high); a larger dose knocks the person out and he is unconscious with no reflexes; and a large enough dose will kill him.

When alcohol depresses the brain, it diminishes the psychomotor activity level. The psychomotor activity level may be measured by the amount of anxiety or tension noted. Diminished psychomotor activity level means relief from anxiety and whatever it is that may bother the individual: insomnia, tension, job, or family pressures. When the person's blood alcohol rises, his psychomotor activity level goes down; he is relieved, relaxed, less anxious, less frightened, less worried than before. But as soon as the blood alcohol level starts to fall, this sedative effect diminishes, and even a big dose, such as a couple of jiggers, wears off very rapidly after the second hour. If that were all, there is a distinct possibility that we might not have the disease called alcoholism, because under those circumstances, an individual could drink to get relief, his anxiety level would diminish, the drink would wear off, and he would come back to where he was before. But that is not what happens, because there is another effect that acts in the opposite direction.

The second effect is to increase the psychomotor activity level. This increase takes place immediately after taking a drink, but is not immediately felt be-

cause the change is less intense than the sedative effect. This latter lasts two or three hours, while the opposite or agitating effect usually lasts for about 12 hours after one big drink. Therefore, as the short-term sedative effect wears off, the other effect of alcohol—increased psychomotor activity—becomes apparent. No one in this world can get a sedative effect from any known drug without it being followed by an agitating effect which wears off more slowly.

Near the end of the second hour after the original drink, when the sedative effect wears off and the agitating effect starts to gather momentum, the individual is more tense than he was before he drank at all. And so he will have another drink and the anxiety level will diminish again, but in about two hours, the psychomotor activity level will rise again, higher than ever. This cycle of increased tension, drinking, short-term sedative effect, longer-term agitating effect, higher tension, drinking again, can go on for some time. Eventually, however, a point is reached when decreasing the psychomotor activity level to a really low state is difficult, no matter how much alcohol is taken. This is because the agitating effects from all of the previous drinks are cumulative.

This agitating effect occurs in experimental animals and in humans; it is inherent in the pharmacology of the drug. You don't have to be an alcoholic in order to experience it. Anyone gets this effect if he drinks enough. For example, after an evening of heavy social drinking, you may have a hangover, the common name given to this condition of after-agitation. A drink (hair-of-the-dog) will relieve this because it provides sedation to counteract the agitation of last night's drinking. Of course, the morning drink is going to be followed by its own agitation for another 12 hours, but the drink may get you through a trying period until you begin to get a decrease in the agitating effects of the heavy drinking from the night before. By afternoon, you are feeling pretty well again. If, however, an individual has been drinking heavily over a long period of time, it may take many days for his psychomotor activity level to return to its normal state.

The person who has taken so much alcohol over a protracted period of time that his psychomotor activity level is extremely elevated may suffer one of several effects. He may shiver and shake, pace back and forth, sweat, palpitate, and show great agitation and tremulousness. This has been called a withdrawal state or syndrome, which is something of a misnomer since the individual may still be drinking all he can hold. However, his agitated condition is breaking through because he has raised it so high that no amount of current sedation can possibly reduce it to bearable levels. If at this point he runs out of money or has an accident, or for some other reason stops drinking and is left in his agitated state with no current sedation, he may suffer an extremely severe withdrawal syndrome. He may get alcoholic hallucinosis, which means basically that his brain is so irritable it sees, hears, or feels things that are not there. It makes up its own sensory input. And if the individual is even sicker, he will develop a condition known as delirium tremens (D.T.'s), in which not only the sensory input but the motor output has become tremendous, and he is literally unable to stop moving. He paces around, tears at his bed linen, hallucinates actively. A characteristic of this delirium is not only the tremulousness, but also absolute terror. The individual behaves as though someone were attempting to kill him. His psychomotor activity may reach the point where it causes spontaneous generalized convulsions.

Basically, this is a condition in which the brain is tremendously over-agitated. Thus, the man who merely had six drinks last night and is edgy this morning and the man with spontaneous seizures and a full-blown case of delirium tremens are suffering from the same disease caused by the pharmacologic effects of the sedative drug. It is just a matter of how much you take and how long you take it. One can produce D.T.'s with seizures in any individual at will, and in fact this has already been done with human volunteers who were not alcoholics. Probably the greatest single cause of adult onset convulsions in the U.S. today is alcohol. With a man who develops seizures in middle life, has never had them before, and is a heavy drinker, the cause is usually alcohol, not a brain tumor.

Up to now, we have assumed that what is happening is a reversible phenomenon, but this is true only up to a point. The central nervous system contains the only cells in the human body which never regenerate. Every other cell, including those of the peripheral nerves, can grow back or reduplicate, but brain cells, once destroyed, do not. The individual is born with the maximum number of brain cells he will ever have, and from then on, he has a decreasing amount throughout life. He never gets any more, and he is losing some, probably, every day of his life. Brain cells are destroyed by traumatic injury, by arteriosclerosis (less blood supply going to the brain as the person gets older) or by toxic substances. Fortunately, the individual may have many more brain cells than he needs, and if 10% of them are destroyed, the probability is that nobody will know the difference. On the other hand, if you lose 20% to 30%, even you may become aware that the memory is not quite there, that you can't think your way through a problem the way you used to. The brain just shrinks and eventually will be half the size of a normal brain. In a chronic alcoholic, after many years of drinking, postmortem examination will show

anatomic wasting of the brain. Now the alcoholic may, of course, do other things to his nervous system from poor eating habits, but the probability is that he can do this damage just with ethyl alcohol, even though he has a good diet the whole time, because ethyl alcohol can apparently injure the brain biochemically. It is probably a reversible injury most of the time, but not always, so that eventually brain cells will be destroyed. When enough of them are damaged, there are irreversible changes in the behavior and the psychological status of the individual. These may never return to normal no matter how long the person is sober and follows a good diet.

The effects of alcohol on other parts of the body are relatively unimportant, since they involve but a minority of heavy drinkers when compared with the effects upon the brain, reversible or not, which take place in 100% of alcoholics. For example, cirrhosis of the liver occurs in about 8% of alcoholics and 1% of the nonalcoholic population. There is also pancreatic disease in a very small percentage of alcoholics and an increased likelihood of pulmonary infections perhaps due to the sedation of the patient so that he does not adequately clear the secretions from his chest. There is also alcoholic cardiomyopathy, a disease of the heart muscle due to heavy intake of alcohol over a period of many years. All of these complications of heavy ethanol ingestion are comparatively rare.

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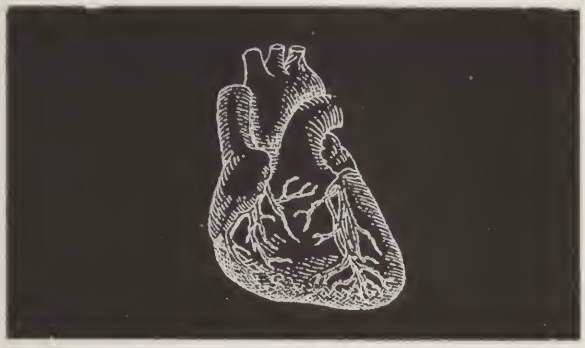
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A Service of the Heart Association of Maryland

the heart page

Cardiac Irritability Secondary to Sympathetic Overactivity

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A consequence of intensive observation of patients in coronary care units has been an enhanced awareness of cardiac arrhythmias. Principal among these irregularities have been those characterized by excessive irritability of the atrial and ventricular myocardium producing premature or ectopic beats.

Many disturbances of cardiac activity are associated with certain stages of coronary artery disease; indeed, it is probable that this disease is the most common cause of ectopic electrical activity. It is important to realize, however, that there are other causes of cardiac irritability. Some of these comprise a group characterized by increased activity of the sympathetic nervous system, by elevated levels of adrenal medullary hormones, epinephrine, and non-epinephrine or both.

Throughout the cardiovascular system, adrenergic receptors play important roles in controlling local and systemic hemodynamics. The heart is sensitive to alteration of sympathetic activity; it, however, is responsive only to beta-adrenergic stimulation. Such activity produces potent central effects, such as increased force of myocardial contraction, increase in heart rate, increased ability of certain cardiac tissues to conduct an electrical impulse, and increased automaticity. The latter is manifest by cardiac irritability and premature beats. Of course, not all factors which result in enhanced sympathetic activity will produce all of the effects mentioned. Exercise and augmented adrenergic discharge related to the anemic state, for instance, will often evince tachycardia and positive inotropism; such conditions will usually not produce excessive myocardial irritability.

Certain other disease states, however, are not infrequently associated with ectopic arrhythmias probably related to excessive sympathetic discharge. Pheochromocytoma with elevated production and circulation of sympathetic agonists is characterized by marked peripheral and cardiac effects; arrhythmias can be a disturbing feature. Thyrotoxicosis, through complex and potent influences, can produce prominent sympathetic activity. Atrial and ventricular irritability such as atrial flutter and fibrillation and premature ventricular contractions are seen. Recently, similar findings have been noted in tetanus. Just as external manifestations can be attributed to somatic neuromuscular irritability, so indeed can the profound diaphoresis, hypertension, vasoconstriction, and cardiac excitement be linked to sympathetic nervous system irritability.

In general, therapeutic efforts in myocardial irritability are directed at suppression of ectopic foci. Agents such as procainamide and quinidine are relatively nonspecific suppressants of electrical irritability. These drugs might be used appropriately to counter ectopicity due to any cause. Quinidine sulfate is usually given orally in doses of 200 mg to 400 mg every six hours; procainamide, 500 mg every six hours, is given by the same route. Recently lidocaine, successful as a local anesthetic, has been recognized as an effective antiarrhythmic agent. With a

mode of action similar to that of quinidine, this drug is given intravenously. An injection of 50 mg to 100 mg followed by an infusion of 1-4 mg/min is commonly used. Lidocaine has enjoyed great use in intensive care units, particularly for ventricular arrhythmias.

Myocardial irritability related to increased adrenergic activity is also amenable to another form of therapy. If, as suggested above, arrhythmias are precipitated by enhanced sympathetic discharge, then blockade of this mechanism should ameliorate the condition. This seems to be the case with the use of beta-adrenergic blockade. Propranolol, the only such drug currently available, has been suggested to block beta activity, both peripherally and centrally in thyrotoxicosis, pheochromocytoma, and tetanus. In addition to beta-antagonism, propranolol possesses a nonspecific quinidine-like action rendering it useful as a general antiarrhythmic preparation. This drug is most effective in the acute situation when given intravenously by slow injection of 0.5 mg to 1 mg repeated after 30 to 60 minutes as needed.

It must be cautioned, however, that propranolol and other beta-adrenergic blocking drugs are to be used sparingly, if at all, in those situations in which cardiopulmonary integrity is dependent upon high levels of sympathetic activity. Patients with bronchial asthma and moderate to severe heart failure may be adversely affected by the administration of drugs which antagonize beta activity. Similarly, situations characterized by bradycardia or heart block or both might be aggravated by antisympathetic medication.

In conclusion, myocardial electrical irritability may have many causes. Nonspecific suppressant therapy may be beneficial in many cases. In certain cases in which sympathetic overactivity can be implicated as a mechanism for ectopic activity, drugs which provide beta-blockade may play a decisive role in management.

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
health department

Health Highlights of 1970

A record-breaking reduction in the number of new active cases of tuberculosis was the most outstanding public health achievement for Baltimore city in 1969. The drop, a dramatic 20% in comparison with the previous year, is a major breakthrough in the city's fight against this disease. New active cases totaled 500—down 122 cases from the 622 reported in 1968. Particularly gratifying is a 53% drop in the incidence of tuberculosis in children under 15 years. Twenty-eight youngsters were victims of the disease in 1969, compared with 60 the previous year.

The gains have been achieved through the infusion of federal funds and the direction given by Allan S. Moodie, MD, Director of the Bureau of Communicable Diseases and an international authority on tuberculosis control.

In 1969 the city's budget for tuberculosis was $925,000, of which $389,000 was provided by the U.S. Public Health Service. These funds made possible the expansion of several recent developments in prevention and treatment. During the past five years the number of residents on antituberculosis drugs has grown from 2,700 in 1965 to 6,750 in 1970. About 50% of this latter group are being treated for active disease while the remainder are persons who are infected with the germ as indicated by the tuberculin test. In view of recent cutbacks at the federal level, no funds have been allocated for tuberculosis programs by the Public Health Service to Baltimore city for 1970. Unless the state and city governments are able to fill the gap, our advance against tuberculosis will be short-lived.

Other Significant Accomplishments

1. With leadership by the Baltimore City Health Department, an aggressive, coordinated attack on malnutrition initiated by the Mayor's Task Force on Nutrition in cooperation with city, state, and federal agencies, including some voluntary groups. Improvements included an expanded school lunch program, greater availability of food stamps, and an iron-enriched milk program for children in Model Cities and those from poor neighborhoods. Staff members from the Department also participated in the White House Conference on Nutrition.

2. The expansion of alcoholism services through training and education, counseling in the Municipal Court, establishment of a recreation-treatment center, and the appointment of a liaison counselor to state mental hospitals and improved transportation for alcoholics to these institutions.

3. The formation early in 1969 of a Mental Health Advisory Council to evaluate the city's mental health programs and to recommend needed changes. This was followed by the appointment of the Reverend Fred Hanna as Coordinator for Drug Abuse Programs and the extension of mental health services for children in the Eastern and Southeastern health districts by additional staff and facilities. Another forward step in meeting mental health needs included the implementation of a Geriatric Evaluation Service that aims to prevent unnecessary mental hospitalization of the elderly through utilization of community resources.

4. A new approach to rat control and environmental hazards through the establishment of a 34-man Sanitary Enforcement Division which is coordinating its efforts with the Department's Rat Eradication Program and other city agencies and civic groups.

5. Progress in air pollution control through a $267,000 grant from the U.S. Public Health Service to reinforce current activities, industry cooperation in the installation of needed air pollution control equipment, and enforcement of the open-burning ban.

6. Increased family planning services supported by a $400,000 U.S. Children's Bureau grant to the Baltimore Maternity Center.

7. The inauguration of a German measles immunization program for school children as part of

a state-wide campaign conducted jointly by the state's medical societies and health departments.

8. A dental care program for Model Cities school children and other children in selected schools in which a new long-lasting fluoride paste was applied to the teeth of 10,000 children to prevent tooth decay. By June 1970 some 30,000 children will have received this treatment.

Population

The estimate of the resident population for July 1, 1969 was 907,000 persons. This indicates that the population of Baltimore city has continued to drop, and that 11,000 persons left the area between July 1, 1968 and July 1, 1969. This decline is the net result of a sizable drop in the white population from 505,000 to 489,000 persons and an increase of approximately 5,000 persons in the nonwhite population (from 413,000 to 418,000). In 1969 the nonwhite population constituted 46% of the total population compared to 45% in 1968.

Births

With a drop of approximately only 500 in the number of live births among the city's residents in 1969, compared to annual declines of 1,000 or more in the last several years, it appears that the recent period of rapid decline in the number of resident births is leveling off. In 1969 there were 16,196 resident live births, 3% below the number for 1968. During the previous two years, the annual declines had been in the range of 6% to 7%.

Deaths

The resident death rate of 13.0 deaths per 1,000 population showed little change from the rate of 12.8 for 1968. However, there were several noteworthy changes in the specific causes of death.

1. Although the number of deaths from all forms of cancer decreased slightly, deaths resulting from cancer of the lung continued to increase with 479 persons dying from lung cancer in 1969 compared to 412 in 1968 and 398 in 1967. In the last 5 years, lung cancer deaths have increased by 36%.

2. The number of accidental deaths dropped by almost 15% from 498 in 1968 to 424 in 1969 with all categories of accidental deaths showing declines. This is the third straight year showing a decrease in resident deaths resulting from accidents.

3. The infant mortality rate declined by 3.5% after a sudden increase in 1968 which interrupted the steady annual downward trend of the previous three years. In 1969, there were 27.5 deaths per 1,000 live births compared to 28.5 in 1968 and 26.2 in 1967. Maternal deaths totaled eight, the same as for 1968 and 1967.

4. Leading causes of death according to provisional statistics of the City Health Department's Bureau of Biostatistics were as follows: heart disease—4,524, up 22 deaths from 1968; cancer—1,986, down 20; cerebral hemorrhage—852, down 107; pneumonia—369, down 80; diabetes mellitus—364, down 47; cirrhosis of the liver—350, up 21 deaths; and congenital malformations and diseases of early infancy—329, down 29. Homicides were fewer in 1969 by 15 deaths while suicides rose from 98 in 1968 to 113 in 1969.

Reportable Diseases

Among those diseases for which preventive vaccines are available, there were no cases of diphtheria or poliomyelitis, one case each of tetanus and typhoid fever and only eight cases of whooping cough among city residents in 1969. Although there were slightly more cases of measles reported in 1969—a total of 63 compared with 56 in 1968—continuation of the incidence of this disease at such low levels compared to case counts of 1,500 to 2,000 during the first years of the decade marks the impact of the introduction of a preventive vaccine for this disease.

Cases of other childhood diseases—chickenpox, mumps, and German measles—were near the 1968 levels.

Reports of gonorrhea increased sharply in 1969 with 9,822 cases reported compared to 7,379 in 1968. Much of this 33% increase has resulted from the introduction of screening examinations for gonorrhea during routine examinations of women at selected hospitals and clinics.





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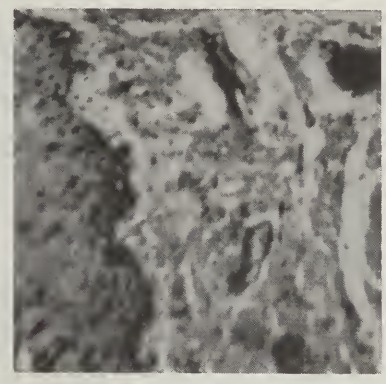


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Cytomegalovirus and the Post-Transfusion Syndrome

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The crucial need for first evaluating the potential clinical advantages of prescribing the transfusion of blood in contrast to the risks involved before it is administered has been well established in medical practice for many years. Recently, a new risk has been clearly delineated—the chance of infecting the recipient with cytomegalovirus inclusion disease (CID), which may be serious or fatal in some patients. It seems incumbent that pathologists and others who may give consultations prior to transfusions should be informed regarding this hazard.

An editorial in *The Lancet,* September 6, 1969, gives an excellent review of this interesting and challenging complication called the post-transfusion or the post-perfusion syndrome or post-transfusion mononucleosis, first reported by Battle and Hewett in 1958[1] and, subsequently, by many others. Characterized by fever, splenomegaly, and atypical lymphocytes in the blood, its development three to six weeks after transfusion led many to the opinion that it resulted from an infection transmitted with the transfused blood. First observed in patients following open heart surgery, the post-transfusion syndrome was also found to appear after simple transfusion. This narrowed the investigation of possible causes. Such factors as age, sex, and blood group of the patients involved could not be correlated in the various cases studied, nor could the underlying diseases for which the transfusion was given, the type of surgery, the technique of the transfusion, or the use of blood additives. One common factor remained—the transfusion of fresh blood (less than 24 hours old) often used in large amounts.

Observations by Klemola and Kaariainen in Finland[2] pointed out in 1965 the titer-rise of antibodies to cytomegalovirus (CMV) in patients with "seronegative mononucleosis". All five of their reported cases, like nearly all of those subsequently reported, proved negative to the Paul-Bunnell heterophil test. Kaariainen and associates[3] documented in 1966 the recovery of CMV in one of five additional cases. In later work by Lang and associates[4,5] at the Massachusetts General Hospital at Boston and the Duke University School of Medicine in Durham, N.C., virus was recovered from all patients—from the urine, the throat, or from leucocytes.

These studies clearly establish an association between the post-transfusion syndrome and cytomegalovirus infection. But whether this infection is transmitted by the transfused blood or becomes manifest by activation of a previously inapparent harboring

of the virus is not conclusively proven. Studies indicate that the antibody response following the transfusion is primary, rather than due to an anamnestic response of immune mechanisms sensitized by previous exposure to the virus. The increased antibodies developed in these cases are of the IgM group of globulins, such as those usually developed as new-formed antibodies after a primary infection.[6] Furthermore, the latent period after transfusion before antibodies rise to detectable levels is too long to represent simple recall. The question of passive transfer of antibodies from the donor to the recipient has also been considered, but such antibodies are short-lived in contrast to antibodies formed endogenously. The possibility exists that a recipient who does not have pre-existing antibodies against CMV may be more susceptible to the post-transfusion syndrome. Paloheimo, an associate of Kaariainen and Klemola,[7] found that such recipients may indeed be more susceptible. However, they found that while pre-existing antibodies may modify the course of the post-transfusion syndrome, they do not give solid protection against it. Further studies on this subject are needed, since it has been found that the CMV is antigenically heterogeneous.

Knowledge gained so far as a result of the observations from Helsinki[2] shows: (1) The clarification of at least three types of CMV infection, and 2) The danger of the post-transfusion syndrome. Earlier observations tended to divide cases of CMV infection into only two groups: either a serious disease, with mental retardation possibly associated with subependymal brain degeneration and calcification, or a mild or inapparent infection followed by a rise in antibodies. A case similar to those in this latter group was found in a study by Foster and Jack,[8] who stored donor serum and then took subsequent specimens if the recipient developed the post-transfusion syndrome. One such "donor" of the syndrome had developed a coryza-like illness; the donee developed post-transfusion syndrome. In another patient complaining of no symptoms, CMV was isolated from the urine. Now, however, it seems that a third group of cases of CMV infection is indicated—those with the post-transfusion syndrome. This infection is usually benign and self-limiting, manifested by the fever, splenomegaly, and lymphocyte findings mentioned above, and characteristically, by the absence of pharyngitis. Test results of liver function often are abnormal, but clinical evidence of liver disease is rare. If lymphadenopathy is present, it is minor. Some patients have had a skin rash.

Merely because the post-transfusion syndrome is in itself a mild illness should not dispel the concern of physicians: Patients with impairment of the immunological mechanisms either as a result of disease or following immunosuppressive therapy are particularly susceptible to opportunistic infections, and CMV has been found to cause death in such patients. Of particular importance is the likelihood, following transfusion of fresh blood to a pregnant woman, of transmitting the CMV infection to the fetus *in utero*. The development of congenital CMV, or even CMV in the newborn, is a serious complication.

From the practical viewpoint, prevention through adequate consultation is of prime importance. If transfusion of a pregnant woman is absolutely necessary, the following precautions seem indicated: 1. The transfused blood should, if possible, have been stored over 24 hours. 2. Some serum from the pilot tube of donor blood should be stored frozen for at least eight weeks. (As isolation of this delicate virus requires seven to ten days, cultural studies would be useless and costly.) 3. If the recipient develops symptoms suggestive of the post-transfusion syndrome, the donor should be recalled and specimens of blood, urine, and throat washings (or a pharyngeal swab taken on a dry, sterile cotton applicator then placed in 2-3 ml nutrient broth) should be taken for virus-isolation studies from both the donor and the recipient; subsequent blood from the recipient at intervals of 14 and 21 days should be taken for comparative determination of antibody level. These specimens should be sent, without delay of more than two to three hours, to the Virology Division of the Maryland Department of Health Bureau of Laboratories. If longer delay cannot be avoided, the blood serum should be separated and, along with the other specimens, should be frozen and shipped as soon as possible at dry-ice temperature. A careful clinical summary giving accurate dates of transfusions, specimens, and of onset of symptoms is of importance to guide the laboratory studies. Consultation is advisable in any unusual case or, of course, when a termination of the pregnancy is considered.

REFERENCES

1. Battle, J. D., and Hewett, J. S.: *Cleveland Clin Q* **25**:112, 1958.
2. Klemola, E., and Kaariainen, L.: *Br Med J* **ii**:1099, 1965.
3. Kaariainen, L.; Klemola, E.; and Paloheimo, J.: *Br Med J* **i**:1270, 1966.
4. Lang, D. J.; Scolnick, E. M.; and Willerson, J. T.: *New Engl J Med* **278**:1147, 1968.
5. Lang, D. J., and Hanshaw, J. B.: *New Engl J Med* **280**:1145, 1969.
6. Hanshaw, J. B.; Steinfeld, H. J.; and White, C. J.: *New Engl J Med* **279**:566, 1968.
7. Paloheimo, J. A., et al: *Am J Cardiol* **22**:624, 1968.
8. Foster, K. M., and Jack, I.: *New Engl J Med* **280**:1311, 1969.



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Spinal Cord Injury: Psychiatric Considerations

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Spinal cord injury evokes emotional reactions that are common to many chronic illnesses which result in physical disability. The relative youth of many patients, the severity of the physical disability, the physical complications and emotional problems which beset the patient's clinical course, and the duration of rehabilitation makes the cord-injured patient one for special consideration. The 21-year-old man who, suddenly after sustaining trauma, experiences loss of motion of the lower extremities, loss of bladder and bowel control, and concomitant loss of sexual function, demonstrates the magnitude of the problem. This paper will review the psychiatric manifestations of spinal cord injuries as they are related to the acute trauma, physical disability, and the ultimate rehabilitation of the patient.

Many young adult men are considered accident prone and their sustaining trauma is frequently the result of behavior called "impulse dominated".[1] Insurance companies charge higher premiums for motorists under 25 because their experience indicates a higher accident rate among this group. The assertive personality factors that contribute to "accident proneness" in the young man may also contribute to the aggressive and sometimes angry behavior which results in difficult behavioral management problems after injury. The young patient who has not settled the important issues concerning his future, in particular his vocation, marriage, and social ambitions, and who is attempting to test and challenge the environment in a manner which will ultimately decide the course of his adjustment, is also a challenge to a treatment team who accepts responsibility for his medical care and rehabilitation.

Paralysis: Cord injury that produces paralysis, ie, paraplegia or quadraplegia, renders the patient helpless and frustrated. Initially, the hope for recovery of function is supported by the patient's use of denial and sometimes the attitude of "wait and see" that prevails among those providing medical care to the patient. Those patients with severe cord injury will maintain covert hopes of recovery even when the optimistic phase of treatment fades, and these hopes are frequently supported by various sensations in the paralyzed extremities. Day and sleep dreams are filled with imaginary happenings that find the patient walking and carrying on as if he were in the pretraumatic state.[2] The psychological necessity of maintaining body integrity and preserving "body image" is normal and is found in all patients who are severely traumatized. This point is emphasized by the patient who, after years of paralysis, will ve-

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hemently refuse amputation of limbs which is deemed essential by the surgeon to cover massive and sometimes life-threatening ulcerations of the patient's buttocks. It is indeed unfortunate that the vast energy the patient expends in wishing and hoping for total recovery cannot be used in facing the reality of the task that lies before him, ie, his rehabilitation and return to society as a functioning person. Since each patient must use his energy in this manner, hoping for total recovery, it is foolhardy to even consider his immediate adjustment a possibility. Only after an appropriate length of time can he be expected to accept his injury and prepare for his future.

The patient's psychological need to maintain control of his own body functions may reduce his motivation for participating in his physical rehabilitation. The rehabilitation team's efforts are thwarted by the patient who demonstrates feelings that the rehabilitation program planned for him is really not necessary. The goals of treatment sought by the patient and the goals of the treatment team are different, and a "treatment struggle" is often encountered with its many problems. When the patient comes to accept his disability and his need for rehabilitation, he has reached an important milestone in his overall adaptation to disability. This acceptance indicates that not only has the patient given up many of his hopes for complete recovery, but he has also worked through a grief reaction which involves accepting his loss (paralysis) and also accepting the fact that he will never regain his "old self".

Bowel, Bladder, and Sexual Function: These functions are grouped together because patients who experience these losses of function tend to group them this way in their minds. To help the patient separate his thoughts of excrement and urine from thoughts of sexual function is a useful concept. Following loss of these functions, the patient feels "dirty", degraded, and inadequate, and experiences high anxiety concerning his loss of "manliness". Frank and open discussion concerning these losses of function and what function the patient may anticipate for the future can be very helpful, rather than leaving the patient confused and with unrealistic expectations. Many paraplegics make a sexual adjustment that they feel is rewarding, since they are frequently able to satisfy their sexual partner.[3] Genitopelvic sensations may be absent and sexual feelings and urges are usually reduced.[4] This combination of factors helps to reduce the intensity of need for sexual self-satisfaction. The quality of sexual adjustment is, of course, dependent on the maturity of the cord-injured patient and his spouse or partner.

Emotional Reactions: The most common psychological response to acute disability following trauma is depression. All patients with spinal cord injury show an immediate depressive mood and affect which is deemed situational.[5] Varying degrees of anxiety accompany the depression and are frequently related to the amount of pain and the severity of disability. When the patient's cord injury results in paraplegia, the depression may be severe and last many months. This reaction is normal and is probably best understood if the patient is considered to be "in mourning" for his personal loss, ie, the loss of physical stability and mobility.

The intensity of this depression will also vary according to the psychological defenses that may be used by the patient. The paraplegic who uses conscious and unconscious "denial" that he is injured and disabled may appear cheerful and relatively unconcerned about his physical status. If this defense is sustained, the patient may take an unrealistic attitude toward his injury and disability, hospital care, and rehabilitation. Most patients will utilize this defense for varying lengths of time, and it allows for periods of good mood and low anxiety which are a welcome relief to the patient, and to the staff. Since the patient must eventually face the realities of his situation, this defense is not sustained, and the patient finds himself in periodic depths of despair.

The physician and hospital staff who are responsible for the care of the paralyzed patient will intuitively manage the patient's use of denial. This is done appropriately in most cases and without the staff being able to verbalize the basis for their interactions with the patient. It is not unusual to find that patient denial is supported by the staff immediately after injury to avoid the patient becoming overwhelmed with anxiety. This may lead to later distrust of the medical staff whom he feels was not honest with him. Conversely, patient denial may be interrupted by a "heart to heart" or "man to man" discussion between the patient and staff when denial is interfering with and deleterious to patient care or rehabilitation, or both. At this stage he may cling to the hope, previously instilled by well-meaning staff, of further improvement, and thus prolong his adjustment period.[6]

The reactive or situational depression can extend beyond the normal length of time, and a pathological depressive reaction then ensues. The patient may experience insomnia, have crying spells, express guilt feelings, and berate his own person. Outside interests are severely restricted, and the patient adopts the attitude that he does not care if he lives or dies. He may harbor suicidal ideation but will rarely attempt suicide.[5] Pathologic depression is sometimes a difficult diagnosis to make since it overlaps the reactive depression. Diagnosis is established by the degree of depression and the length of time that it continues after injury. The reactive depressions tend to subside on their own after two to four months and without interventions other than the medical and emotional support usually provided the patient by the treatment

team. Supportive psychotherapy and antidepressant drugs may become necessary and are useful in treating the pathological depression.

Depression can be expressed by maladaptive behavior. This may take two forms. Some patients may severely regress and show an infantile type of reaction. They wish to be cared for completely and cannot be motivated to become active in their own treatment. The other form of maladaptive behavior is the aggressive reaction evidenced by the hostile, argumentative patient who alienates the ward staff. This type of patient will challenge those responsible for his care with hostile, negative attitudes and will tend to berate the performance of the nursing staff. The depth of this patient's depression is sometimes exhibited when the hostility and anger give way to a crying spell. Both of these forms of behavior are a challenge to those caring for these patients, and each patient's reaction deserves careful consideration. Regular meetings of the staff where individual patient behavior can be considered in some depth and detail can be very helpful to both the patient and the staff. In fact, all members of the team who have responsibilities to the patient should attend such meetings in an attempt to solve the sometimes severe problems encountered in the management of these patients. The dangers of these two forms of behavior are that the regressive type will go unnoticed by the medical staff, while the aggressive type will lead to patient alienation and may result in an unconscious decrease in effort on the part of the treatment team.

Adjustment Variables: The variables that influence the patient's eventual adjustment to disability include: 1. the extent of physical injury, resulting physical complications, and the success of his physical treatment; 2. the pretraumatic personality, "What was he like prior to the trauma?"; 3. the level of dependency the patient can adjust to following the injury and while hospitalized; 4. the intensity and duration of the emotional reactions experienced following the injury and the resulting emotional support and treatment supplied the patient by the medical staff and the patient's family; and 5. the patient's physical ability to resume his former vocation and way of life.

The patient who recovers smoothly without multitudes of physical complications and who has the opportunity for quick, effective rehabilitation will present fewer difficulties to the treatment and rehabilitation staff. When physical injury is complicated medically, the patients are apt to experience "setbacks". It is not unusual to hear a member of the treatment team say, "He was fine until he developed the bladder problem after the last surgery." Depression and anxiety are aggravated at these times, and the patient will sometimes suggest he is "giving up". Additional emotional support supplied the patient during these crises and forewarning him of complications that may be anticipated can be helpful in supplying him needed emotional comfort. Optimism concerning the patient's recovery by all those attending the patient is essential when the clinical course is beset with these complications.

The problem of pain and the consideration of tranquilizers is a useful adjunct to the early care of the spinal cord injured patient. Pain tends to interrupt the patient's psychological defenses which are essential to his controlling anxiety. If the anxiety is reduced by tranquilizers, it allows the patient to regroup his defenses and the pain-anxiety cycle may be effectively broken, ie, the pain is made worse as the anxiety level rises and the increased anxiety results in more complaints of pain.

The patient's pretraumatic personality is important.[5] It is difficult to rehabilitate a patient who, in fact, was a psychological or social rehabilitation problem prior to the trauma. If a patient has functioned adequately on social levels and was stable and emotionally mature prior to trauma, you may anticipate that he will function at the same level during the rehabilitative process, barring the possibility of prolonged physical complications. The pretraumatic personality is difficult to assess for the first few months following trauma. If the patient was wreckless, immature, and sociopathic prior to the trauma, this same personality will emerge sometime after the injury and will present many problems in patient care and rehabilitation. Since the magnitude of the disability from spinal cord injury can overshadow the personality factors early in treatment, it is wise to interview the patient's family and attempt to reconstruct the patient's social and vocational history to given an impression of what the patient may be like when he is ready for rehabilitation. It is also helpful to consider the circumstances of the trauma. Patients who feel that their trauma was the result of someone else's negligence, or are resentful because they feel they don't deserve their fate are more apt to prolong the rehabilitative process and become management problems during their course of treatment.

The level of dependency that the patient can assume following his injury is an important factor in his acute treatment and his motivation for rehabilitation. The patient who assumes an exclusively dependent position will present problems of motivation for treatment since he fully anticipates that all of his needs will be cared for by others. This may seem desirable early in the acute treatment stage, but as the patient improves physically, it is noted that "he will not help himself". The treatment staff is apt to express anger toward such a patient for his inability to participate in his own treatment, and this anger will further complicate the patient's treatment because of his reaction to this anger. Regressive behavior is common in these patients and the medical staff will frequently refer to this kind of patient as a "baby".

The staff feels a strain in that the patient is making them completely responsible for his well being and eventual rehabilitation.

The contrasting patient is the hyperindcpcndent patient who resents and, at times, refuses care. Hc will present the staff with a "who needs you?" attitude. It is not unusual that this patient will physically harm himself by trying to do more than he can really accomplish on a physical level. This same patient may show agitation and may throw an object, such as a urine duct, at a member of the treatment staff. It may require a psychiatrist to help resolve this kind of problem in the treatment unit. Working not only directly with patients, but also supplying staff with an understanding of the patient's problem and feelings will frequently alleviate the problem and allows the patient to settle into an optimum dependent position. It is the author's experience that the hyperindependent patient will respond to effective psychotherapeutic interviews more quickly than the very dependent patient.

The patient's family needs special attention, particularly the spouse. The usual difficulty encountered between patient and spouse during the acute treatment stage is the patient's attempt to "push her away". This is at a time when the patient is berating himself and feeling useless, and when he is confused about his future sexual status. Supplying emotional support to the spouse via counselling is essential, particularly if she is emotionally immature. A thorough explanation concerning what she may anticipate in terms of the patient's sexual and other physical functioning is necessary. The result is hopefully that the spouse will reassure the patient. On occasion, the spouse may feel overwhelmed with the patient's need to be dependent, and her inability to successfully reassure him. The spouse who feels overwhelmed by the tragedy that has befallen the family and her husband's demands on hcr, may tcnd to withdraw with very deleterious effects on the patient. A social worker who will cvaluate and help work with the spouse's problems is an important ingredient in the treatment team. Although there are no statistics available, our clinical impression is that the divorce ratc is high in paraplegic marriages.

The patient's ability to assume his former vocation is sometimes vital to his self-image. This is a particular problem if the patient is a skillcd worker and, following severe physical trauma, finds that he cannot continue in his former job. The bricklayer who is earning $4 an hour and who is not competent to do other work is a classic example. These patients are very resentful and extremely difficult to rehabilitate vocationally. Not only is their physical self-image shattered, but also their status as a high-wage earner. The level of depression is often extreme in these patients and several attempts at vocational rehabilitation may be necessary before any success is achievcd. It should also be noted that if the patient is maintained in the hospital at the same level of income that he was earning prior to injury, this may decrease to some extent his motivation for rehabilitation.[7]

Summary: This paper presents somc of the emotional complications of spinal cord injury, thcir evaluation and treatment. It also reviews the ability of various typcs of patients to adjust to their disability and shows how a treatment team may be helpful to these patients. The theme of this paper is that a team approach, utilizing all aspects of medical, surgical, social and psychological resources, is necessary for the total recovery of these patients.

REFERENCES

1. Fordyce, W. E.: Personality Characteristics in Men With Spinal Cord Injury As Related to Manner of Onset of Disability, *Arch Phys Med and Rehab* **48**:321-325, 1964.
2. Money, J.: Phantom Orgasm in the Dreams of Paraplegic Men and Women, *Arch Gen Psychiatry* **3**:373-382, 1960.
3. Comarr, A. E.: Physiologic Aspects of Disturbed Neuromuscular Functioning in the Paraplegic, *Am J Surg* **91**:149-151, 1956.
4. Hohmann, G. W.: Some Effects of Spinal Cord Lesions on Experienced Emotional Feelings, *Psychophysiology* **3**:143-156, 1966.
5. Mueller, A. D.: Psychologic Factors in Rehabilitation of Paraplegic Patients, *Arch Phys Med and Rehab* **43**:151-159, 1962.
6. Weiss, F. G., and Bors, E.: Attitudes of Patients in a Paraplegic Center, *J Soc Case Work* **29**:60-65, 1948.
7. Nagler, B.: Psychiatric Aspects of Cord Injury, *Am J Psychiatry* **107**:49-56, 1950.

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Penicillin Will Kill 300 in 1970

Penicillin, the "wonder drug" that has been a life saver to millions of Americans, has become a lethal threat to thousands of them every year, say medical authorities.

At least 3,000 or more people in this country went into shock before the end of 1969 after taking the drug.

About 300 died because of it.

And this year the situation could grow worse.

Some authorities believe that the prevalence of pencillin in our food—in meat and milk, for example, from animals treated with the drug—may be sensitizing more people and making them prone to an anaphylactic shock (extreme sensitivity).

And penicillin is the most frequent cause of anaphylaxis.

Yet, clinicians still have no reliable means of telling which patients will have a severe reaction to the drug.

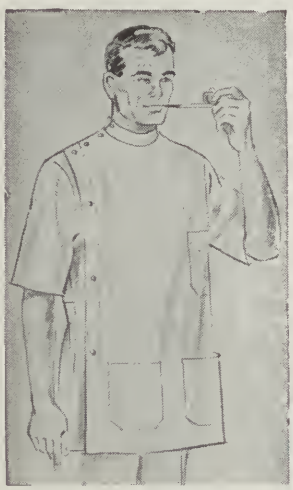
Most physicians today rely on their records, and on a ready bottle of a drug called epinephrine to treat the shock if it develops.

Researchers at several U.S. and Canadian centers are working on tests to solve the problem, but none is currently available to private practitioners. The situation is not expected to change in 1970.

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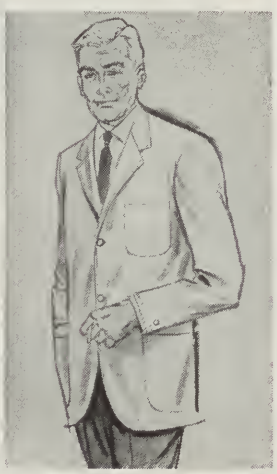
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Benefits of Illness

That society may materially benefit from the illness of the individual is perhaps not too well appreciated by the majority of physicians, continuously indoctrinated as they are from their earliest student days with the necessity for stamping out disease and alleviating suffering. In previous centuries the hypermetabolic state associated with advanced pulmonary tuberculosis inspired many famous artists and composers to heights of artistic accomplishment.

Today, this peculiar synergism between talent and disease is seen most frequently in the realm of the psychiatrist. Many intelligent and gifted persons with manic-depressive psychosis show tremendous creative productivity during their manic swings and will often elect to endure the subsequent episodes of depression rather than have these cyclical swings smoothed out by drugs like Thorazine or lithium.

The superior achievers in our society also seem to be peculiarly prone to develop psychosomatic illnesses when physical and mental pressures become overwhelming. Often, these illnesses appear peculiarly suited to the individual's particular life situation. The singer develops laryngitis; the star pitcher, a sore arm; and the thinking executive, migraine. These illnesses are beneficial in that they allow an honorable and socially acceptable retreat from an overwhelming and ego-threatening situation, thereby preventing personality disintegration. Misguided attempts by physicians to overtreat and cure these essential ills may reduce talent to mediocrity and in rare cases result in complete physical and mental breakdown.

Nobel Laureate Lauds Oranges

Can an orange a day keep the psychiatrist away?

Large doses of vitamin C (found in fresh fruits, especially citrus, tomatoes and vegetables) were highly recommended during 1969's second International Congress of Social Psychiatry.

Taking about ten times the recommended dose of vitamin C daily under a physician's care, according to Dr. Linus Pauling, professor of chemistry at the University of California, San Diego, and a Nobel Prize winner, can provide the average person with:

- Increased vigor.
- Increased protection against infectious disease including the common cold.
- An increased rate of healing of wounds.

In addition the Nobel laureate said he and his colleague, Dr. Arthur B. Robinson, had found an abnormally low level of ascorbic acid (vitamin C) in the body fluids of about one third of schizophrenics they had examined. This was borne out by other investigators.

Did You Know?

Nearly 169.5 million Americans were privately insured against hospital expenses at the beginning of 1969—an increase of 6.6 million over the beginning of 1968.

- About six out of every seven persons in the United States have some form of private health insurance protection.
- Insurance companies insured more than 104 million people as the year began—4.8 million of them over 65 years of age.
- Increases in coverage were registered in all major categories of health insurance in 1968.

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Staff News and Review

Since the last *Library Page* was published in February, Med/Chi has added a full-time Assistant Librarian in charge of Cataloging and Acquisitions—Mrs. Judith Rae Pochciol (pronounced 'Po-shol'). Mrs. Pochciol comes to us from Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania. We welcome her to the Med/Chi staff with pleasure.

Having missed the March issue of the *Journal*, it was too late to invite you to visit the library exhibit at the Annual Meeting, but we hope everybody remembered to browse among the new books on display. The library's acquisitions will increase as we can secure more staff to process orders and cataloging, but new books will not help you if you never visit the library or request that information be sent to you.

On one of Mr. Lee Ash's visits to this library, he found an interesting supplement to the *Danish Medical Bulletin* of November 1969 (volume 16, supplement IX) and wrote the following comments:

> "Studies in the Mediaeval Diagnosis of Leprosy in Denmark" is an exciting and unusual osteo-archaeological, historical, and clinical study, by Johs. G. Andersen, a senior medical scientist in the field of leprosy, while he was on special assignment to the Medical Historical Museum at the University of Copenhagen. As a worldwide study of historical and literary sources, of correlation with osteological remains, and reference to mediaeval and contemporary pathological examples, the volume is a fine demonstration of the application of historiographical principles to some problems of comparative history. Its relevance to medical history and to other literary and historical studies is readily demonstrated in nearly twenty "General Conclusions".
>
> If you have an interest in leprosy, this supplement is available in the Med/Chi library.

* * *

Due to the forced cancellation of the meeting of the Baltimore Chapter, Special Libraries Association, originally planned for the Sunpapers Library to host, the Med/Chi library acted as host for a visit from local librarians to this library. After a short sketch of the library's history, guests were escorted to the upper stacks where Mr. Ash explained the process involved in surveying a historical collection such as ours and showed some of the "gems" he has unearthed there.

This was followed by a smorgasbord at the Deutsches Haus and an interesting and humorous talk by Mr. Ash on "A Variety of Experiences During My Years of Librarianship".

New Accessions

BOOKS

(Arranged by Author and Title)

Abrahams, Harold J.
The extinct medical schools of Baltimore, Maryland. Baltimore, Maryland, Maryland Historical Society, 1969.

Alvarez, Walter Clement.
Little strokes. Philadelphia, Lippincott, 1966.

American Medical Association.
Directory of approved internships and residencies, 1968-1969.

Bauer, Karl M.
Cystoscopic diagnosis; technique and typical findings. Philadelphia, Lea & Febiger, 1969.

Bennett, Arnold.
The human machine. New York, G. H. Doran Company, 1911.

Berne, Eric.
Principles of group treatment. New York, Oxford University Press, 1966.

Burnham, Donald L.
Schizophrenia and the need-fear dilemma. New York, International Universities Press, 1969.

Castleman, Benjamin.
Neurologic clinicopathological conferences of the Massachusetts General Hospital. Boston, Little, Brown, 1968.

Cutting, Windsor Cooper.
Handbook of pharmacology; the actions and uses of drugs. New York, Appleton-Century-Crofts, 1969.

Derrick, John R.
The surgeon's responsibility. Springfield, Ill., Thomas, 1968.

Egan, Donald F.
Fundamental of inhalation therapy. Saint Louis, C. V. Mosby Co., 1969.

Ellis, Richard White Bernard.
Disease in infancy and childhood. Edinburgh, London, E. & S. Livingstone, 1968.

Farberow, Norman L.
Bibliography on suicide and suicide prevention, 1897-1957, 1958-1967. Chevy Chase, U. S. National Institute of Mental Health, 1969.

Finneson, Bernard E.
Diagnosis and management of pain syndromes. Philadelphia, W. B. Saunders Co., 1969.

Gell, P. G. H.
Clinical aspects of immunology. Oxford, Edinburgh, Blackwell Scientific, 1968.

Goldfarb, William.
A time to heal; corrective socialization: a treatment approach to childhood schizophrenia. New York, International Universities Press, 1969.

Goldsten, Stephen E.
Mental health considerations in public health: a guide for training and practice. Chevy Chase, U. S. National Institute of Mental Health, 1969.

The Hospital Council of Maryland Inc.
Planning: Manpower in Maryland's hospitals. Baltimore, The Council, 1969.

Kildeberg, Poul.
Clinical acid-base physiology; studies in neonates, infants, and young children. Baltimore, Williams & Wilkins Co., 1968.

Lingeman, Richard R.
Drugs from A to Z, a dictionary. New York, McGraw-Hill, 1969.

Lutzker, Edythe.
Women gain a place in medicine. New York, McGraw-Hill, 1969.

Mandelstam, Joel.
Biochemistry of bacterial growth. New York, John Wiley and Sons, Inc., 1968.

Medical Society of the State of New York.
Medical directory of New York State. New York, the Medical Society of the State of New York, 1969.

Owens, Mrs. Walker.
McDowell House and apothecary shop, Second Street, Danville, Kentucky. Danville, Women's Auxiliary of the Kentucky State Medical Association, 1961.

Paulson, Moses, ed.
Gastroenterologic medicine. Philadelphia, Lea & Febiger, 1969.

Pearce, John.
Migraine; clinical features, mechanisms, and management. Springfield, Ill., C. C. Thomas, 1969.

Porphyria—a royal malady. London, British Medical Association, 1968.

Prognostic factors in breast cancer: proceedings of first Tenovus Symposium, Cardiff, 12th-14th April 1967. Edinburgh, London, E. & S. Livingstone, 1968.

Regional Publishing Co. Baltimore.
Maryland: local history and genealogical records. Baltimore, Regional Publishing Co. and Genealogical Publishing Co., 1969.

Roberts, Jean.
Hearing levels of adults by education, income, and occupation, United States, 1960-1962. Washington, U. S. Dept. of Health, Education, and Welfare, Public Health Service, 1968.

Roberts, Jean.
Hearing levels of adults by race, region and area of residence, United States—1960-1962. Washington, U. S. Public Health Service, 1967.

Sandritter, Walter.
Color atlas and textbook of tissue and cellular pathology. Chicago, Yearbook Medical Publishers, 1969.

San Francisco Cancer Symposium, 3d, 1967.
The relationship of time and dose in the radiation therapy of cancer. Basel, New York, S. Karger, 1968.

Schappert-Kimmijser, J.
Coding systems for disorders of the eye. Basel, New York, Karger, 1968.

Shaw, Robert R.
Surgery for thoracic disease. Springfield, Ill., Thomas, 1968.

Shepard, Kenneth S.
Care of the well baby; medical management of the child from birth to 2 years of age. Philadelphia, Lippincott, 1968.

Smith, Robert Hudson.
Pathological physiology for the anesthesiologist. Springfield, Ill., Thomas, 1966.

Spencer, Herbert.
Pathology of the lung, excluding pulmonary tuberculosis. Oxford, New York, Pergamon Press, 1968.

Suicide among the American Indians. Chevy Chase, National Institute of Mental Health, 1969.

Thompson, Ronald Bolton.
Haematology. Philadelphia, Lippincott, 1961.

U. S. National Advisory Commission on Civil Disorders.
Report. Washington, 1968.

U. S. National Clearing House for Mental Health Information.
Adverse reactions to hallucinogenic drugs. Chevy Chase, U. S. National Institute of Mental Health, 1969.

U. S. National Clearing House for Mental Health Information.
Volunteer services in mental health; an annotated bibliography. Chevy Chase, National Institute of Mental Health, 1969.

U. S. National Institute of Allergy and Infectious Diseases.
Rocky Mountain Laboratory. Washington, U. S. National Institutes of Health, 1969.

U. S. National Institute of Mental Health.
Research in individual psychotherapy. Chevy Chase, U. S. National Institute of Mental Health, 1969.

U. S. National Library of Medicine. National Medical Audiovisual Center.
Mental health film guide. Atlanta, National Medical Audiovisual Center, 1969.

U. S. Public Health Service. Division of Chronic Disease Programs.
Endocarditis: bibliography compiled from the English language, 1965-1966. Washington, U. S. Public Health Service, 1969.

U. S. Public Health Service. Division of Chronic Disease Programs.
Selected references on rheumatic fever, glomerulonephritis and streptococcal infections. Arlington, U. S. Public Health Service, 1968.

U. S. Public Health Services. Division of Health Care Services.
Working with older people, a guide to practice. Arlington, U. S. Public Health Service, 1969.

U. S. Treasury Department. Bureau of Narcotics.
Prevention and control of narcotic addiction. Washington, U. S. Treasury Department, Bureau of Narcotics, 1959.

Vincent, Clark E.
Human sexuality in medical education and practice. Springfield, Ill., C. C. Thomas, 1968.

Who's who of American women and women of Canada. Chicago, A. N. Marquis Co., 1970.

Wrage, Karl Horst.
Children; choice or chance. Philadelphia, Fortress Press, 1969.

Zacarian, Setrag A.
Cryosurgery of skin cancer, and cryogenic techniques in dermatology. Springfield, Ill., C. C. Thomas, 1969.

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LOCUM TENENS—For OB/Gyn practice in Western Maryland for the month of July. Should be Board certified or eligible, and licensed in Maryland. Future association considered. Write: Box #6, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

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PODIATRIST—Wishes to join multispecialty medical group. Will complete military service July 1, 1970. Licensed in Wash., D.C., Md., and Va. Send reply to: Steven J. Berlin, DPM, Podiatry Dept., USAH Ft. Jackson, S. Carolina 29207.

OPHTHALMOLOGIST—Wants to relocate. Age: 39. Board certified, extensive experience. To associate with another ophthalmologist or group in Baltimore area. Write: Box #5, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

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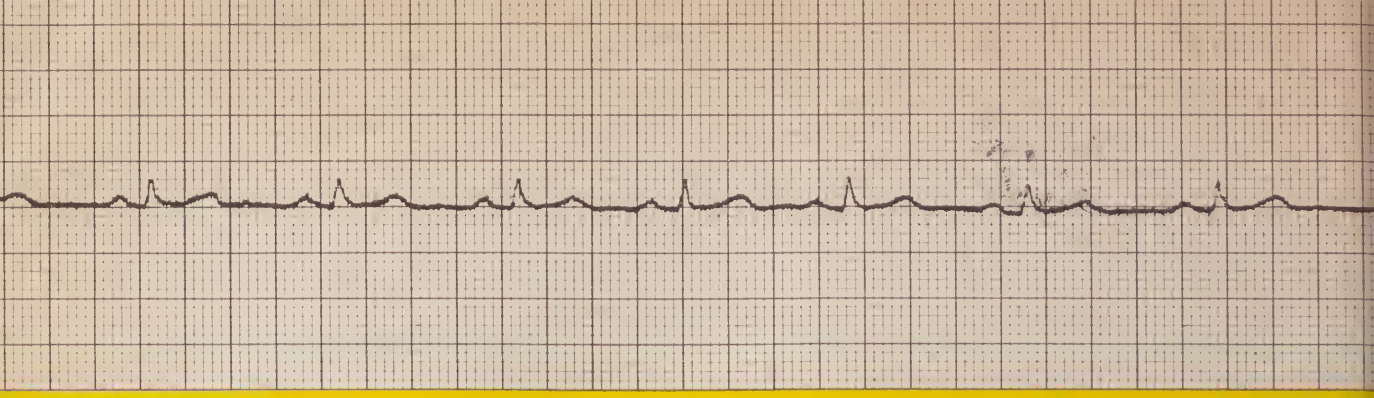
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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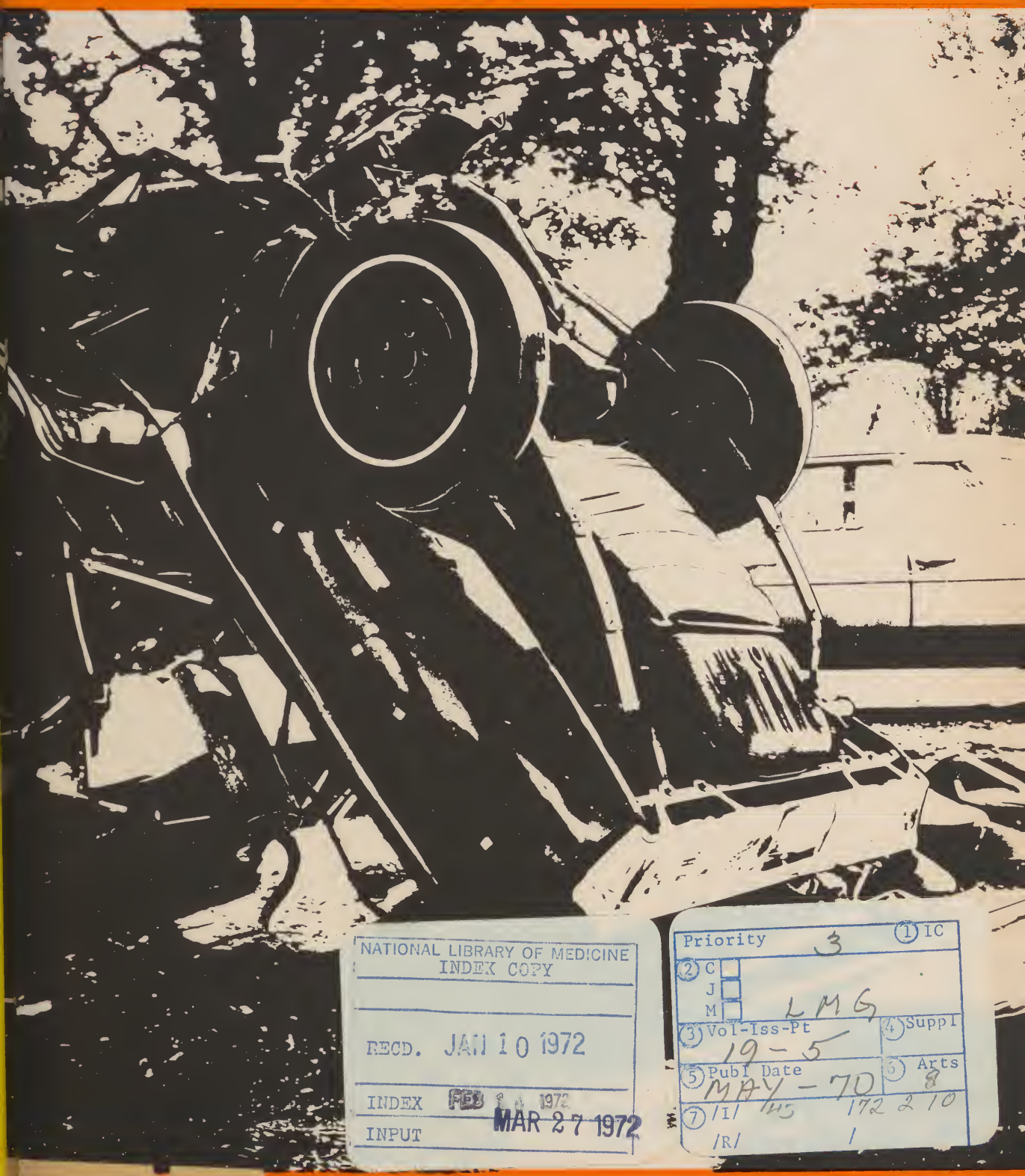
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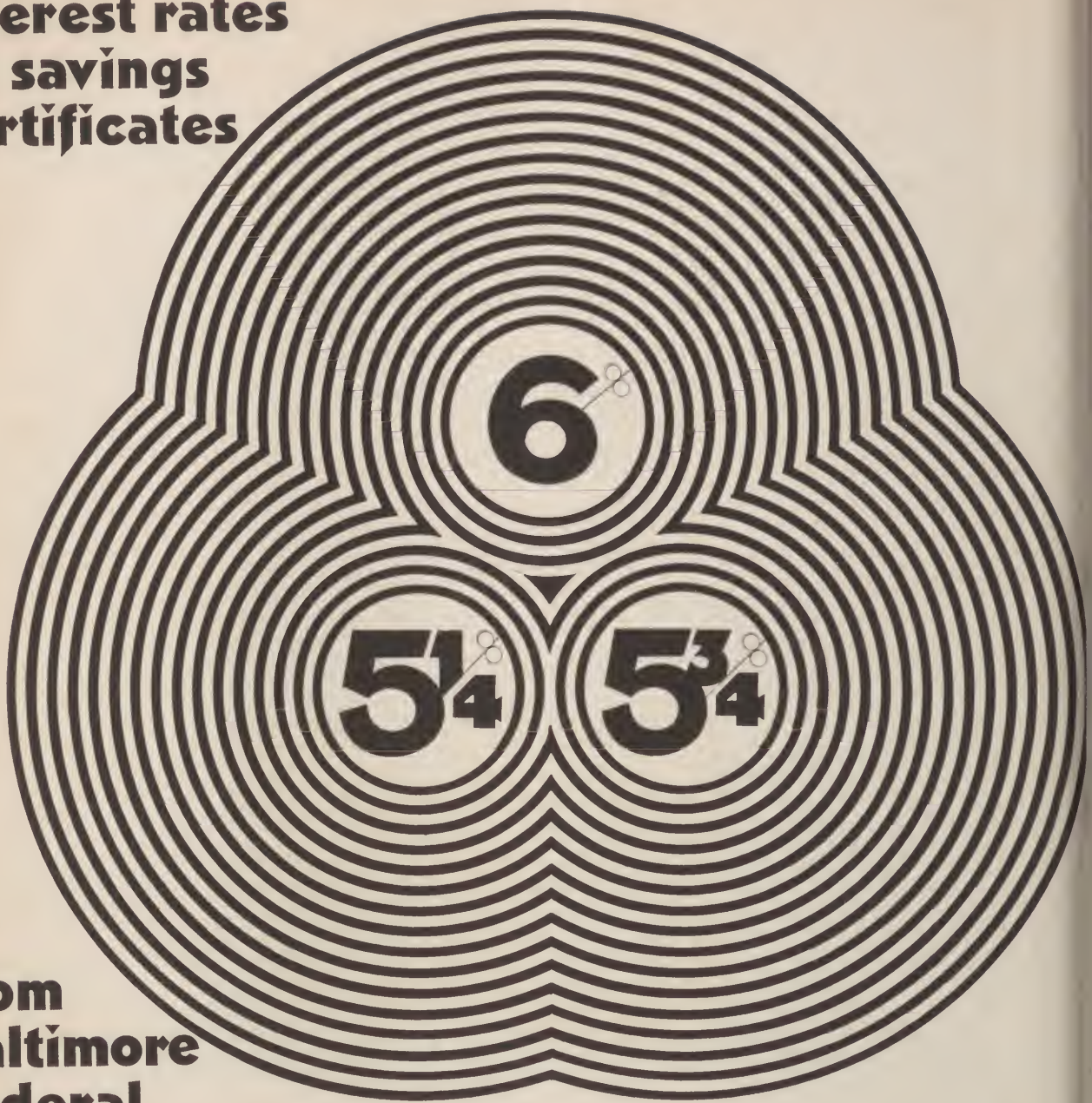
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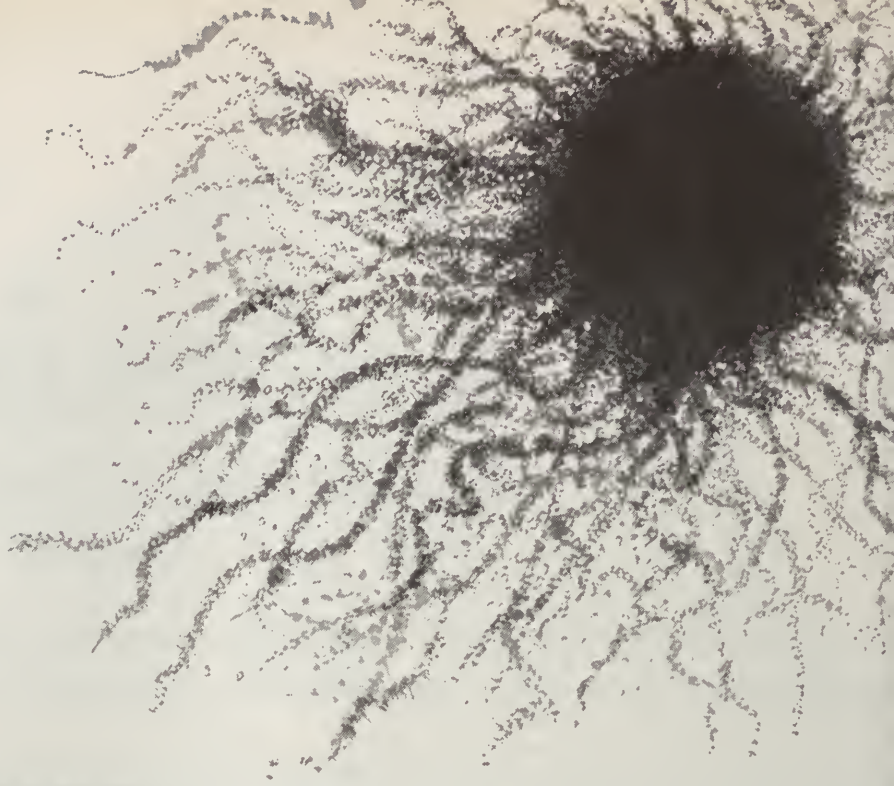
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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VOLUME 19 MAY 1970 NUMBER 5

CONTENTS:

Medical Advisory Board—Five Year Summary, Ruth W. Baldwin, MD 48

Seat Belts: A Habit To Last A Lifetime, Susan P. Baker, MPH; Charles S. Springate, MD 50

"One of the most tragic—and most common—aspects of traffic fatality investigation is the sight of a dead victim in a smashed automobile, sitting on the belts which could have saved his life."

Vision and Driving, Solomon E. Barr, MD 53

"On today's high-speed highways, the driver is constantly pressed for quick reactions to fleeting visual stimuli. For this reason it is necessary that he be able to see well enough to avoid accidents."

Why the Issue Is Loss Reduction Rather Than Only Crash Prevention, William Haddon, Jr., MD 55

"There is no reason why highway loss-reduction countermeasure priorities must parallel the rank of causes. Traditional emphasis only on crash prevention ignores major opportunities for reducing losses to damaged people and property. A standard method is needed for rating vehicles' occupant protection considering limits set by physics and body force tolerances."

The Alcoholic Driver: Can We Cope With A Menace? Maxwell N. Weisman, MD 61

"The excessive use of alcohol contributes to half of all motor vehicle accidents, and alcoholics and other problem drinkers, who constitute but a small minority of the general population, account for a very large part of the overall problem."

Sex, William K. Keller, MD 64

"It seems odd that we physicians, the preventers, the healers, would do so little about a preventable phenomenon—traffic accidents—that kills about 60,000 men, women, and children each year, and injures about 4½ million."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 65

Tuberculosis—Emergence of Gram-Negative Pharyngeal Flora in Hospitalized Patients 87

Library—Catalog Revisions and New Accessions 91

Heart Page—Newer Concepts in Bundle Branch Block, Robert R. Montgomery, MD, FACC 99

Baltimore City Health Department—Summary of Reported Poisonings in Baltimore City 1969 and 1968 101

Alcoholism—The Pharmacological Approach to Alcoholism—Part 2, Stanley E. Gitlow, MD 103

Maryland State Department of Mental Hygiene—The Long-Term Patient .. 107

Maryland State Department of Health—State School Health Council Elects Officers 109

Rehabilitation Notes—Illustrations of Patients With Spinal Cord Injuries, Douglas Carroll, MD 111

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Doctors Take Note **5**

Executive Secretary's Newsletter **9**

Component Society News **13, 37**

Semiannual Meeting **17**

Maryland Association of Medical Assistants **28**

The Month in Washington **32**

Information for Authors **40**

Eye Hazards for Kids **45**

Medical News **68**

Book Reviews **74**

Woman's Auxiliary **77**

MEDIC **82**

Letter to the Editor **98**

Advertising Index **117**

Classified Index **118**

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MAY 15-16, 1970
KENTUCKY OBSTETRICAL AND GYNECOLOGICAL SOCIETY

22nd Annual Meeting: Louisville, Kentucky. Contact: Mervel V. Hanes, MD, Secretary-Treasurer, Kentucky Obstetrical and Gynecological Society, 262 Medical Towers South, Louisville, Ky. 40202.

MAY 15-17, 1970
LONG ISLAND JEWISH MEDICAL CENTER

11th International Symposium on Vectorcardiography: Hotel Americana, New York. Write: Irwin Hoffman, MD, Chairman, Long Island Jewish Medical Center, New Hyde Park, N.Y. 11040.

MAY 16-19, 1970
MEDICAL SOCIETY OF NEW JERSEY

204th Annual Meeting: Haddon Hall, Atlantic City, New Jersey. The program will include scientific sessions, scientific and informational and technical exhibits. There is no registration fee for out-of-state nonmember physicians. Write: The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

MAY 19, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Aldosteronism And Hypertension—University Hospital Experience: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. 21201. Speaker: Thomas Connor, MD.

MAY 20-22, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Clinical Aspects of Infectious Diseases: University of Washington School of Medicine, Seattle, Wash. Co-directors: Robert G. Petersdorf, MD; Wm. M.M. Kirby, MD, FACP; Marvin Turck, MD, FACP. Write: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 21-22, 1970
MARYLAND PUBLIC HEALTH ASSOCIATION

Annual Meeting: Belvedere Hotel, Baltimore. This year's meeting, with the theme "The Challenges of the 70's", will include panel sessions and section meetings. Keynote speaker for the opening session: Rev. Frederick J. Hanna, Coordinator for the Drug Abuse Program in Baltimore. Guest speaker at noon on May 21: Neil Solomon, MD, PhD. Contact: Cornelius W. Kruse, MD, Professor, Department of Environmental Health, The Johns Hopkins School of Hygiene, 615 North Wolfe Street, Baltimore 21205.

MAY 21-23, 1970
MOUND PARK HOSPITAL FOUNDATION/DEPARTMENT OF MEDICAL EDUCATION, BAYFRONT MEDICAL CENTER/UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE/PINELLAS COUNTY MEDICAL SOCIETY/FLORIDA ACADEMY OF GENERAL PRACTICE

Symposium—Pediatric and Adolescent Psychiatry: Tides Hotel and Bath Club, Redington Beach (St. Petersburg), Florida. Fee: $50. 18 accredited hours, American Academy of General Practice. Contact: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

MAY 22-29, 1970
INTERNATIONAL UNION AGAINST CANCER

10th International Cancer Congress: Houston, Texas. The Congress will include scientific sessions, congress panel discussions, scientific exhibits, special postgraduate clinical courses, and specially planned events and cultural functions. For further information, write: Office of the Secretariat, Tenth International Cancer Congress, P.O. Box 20465 Astrodome Station, Houston, Texas 77025.

MAY 25-27, 1970
AMERICAN GYNECOLOGICAL SOCIETY

Conference: Hot Springs, Virginia. Contact: Ben M. Peckham, MD, Executive Secretary, 1300 University Ave., Madison, Wisc. 53706.

MAY 27-29, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Heart Disease-Clinical and Pathological Correlation: Georgetown University Hospital, Washington, D.C. Co-directors: W. Proctor Harvey, MD, FACP; William Manion, MD. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 3-5, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Pathology, Pathologic Physiology and Clinical Aspects of Renal Disease: Georgetown University Hospital, Washington, D.C. Director: George E. Schreiner, MD, FACP. Write: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 3-6, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Postgraduate Course—Intrauterine Development and Fetal Management: Johns Hopkins Hospital, Baltimore. The course will include general morning sessions and afternoon seminar-demonstration small group meetings. Contact: A. E. Seeds, MD, Department of Gynecology and Obstetrics, Johns Hopkins Hospital, Baltimore, Md. 21205.

JUNE 4-5, 1970
MILES LABORATORIES, INC.

4th International Symposium in Molecular Biology: Americana Hotel, New York, New York. The symposium is entitled "Biological Effects of Polynucleotides". Co-chairmen of the scientific program: Prof. Roland F. Beers, Jr., Head, Division of Radiobiology, Johns Hopkins University; Prof. Werner Braun, Professor of Microbiology, The Institute of Microbiology, Rutgers, The State University. Contact: Edward C. Bassett, PhD, Symposium Coordinator, Research Products Division, Miles Laboratories, Inc., Elkhart, Indiana 46514.

JUNE 8-11, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Seminar and Technical Workshop in Exfoliative Cytology in Obstetrics and Gynecology: New York, N.Y. The seminar is limited to 20 participants; the fee is $100. Write: H. L. Riva, MD, 40 Highland Avenue, Short Hills, New Jersey 07078.

JUNE 8-12, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Psychiatry and the Internist: University of Maryland Hospital and Psychiatric Institute, Baltimore. Director: Bernard R. Shochet, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

(Continued on page 39)

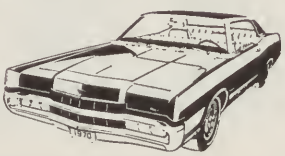
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executive secretary's newsletter

May, 1970

RADIATION EXPOSURE SURVEY

Last month a national house-to-house interview survey was begun to study and evaluate exposure to diagnostic and therpeutic X-radiation. The survey will continue through October.

During the study, radiological practitioners and facilities will be visited to obtain more complete information on X-ray procedures and treatment reported by the household participants. The purpose of this study is to collect data to evaluate the effectiveness of programs in order to improve X-ray practice and reduce unnecessary exposure.

The study is being conducted by the Bureau of Radiological Health of USPHS and the National Center for Health Statistics.

TRIP TO SWITZERLAND

The Faculty-sponsored trip to Switzerland has been planned for October 11 through 18, 1970. Final details have not been completed, but information will be mailed as soon as possible to those who are interested.

MEDICAID MEETINGS SET

The State Department of Health and Mental Hygiene has established a Vendor Relations Review Team. The Team will assist vendors in eliminating delays in payment for services.

Regional meetings have been scheduled and physicians or members of their staff may attend any of the sessions. A complete listing of locations and dates is available at the Faculty office.

LEGISLATIVE ROUNDUP

Look for the last issue of The Assemblyman for 1970. It contains a complete roundup of the legislation adopted at the recently completed session of the General Assembly.

It contains data on legislation sponsored but not enacted into law. These latter issues will probably be raised again when the 1971 session convenes.

ANNUAL MEETING POSTMORTEM

Figures for the 1970 Annual Meeting indicate that attendance was about the same as in 1969. Weather,

ANNUAL MEETING POSTMORTEM (cont'd)

the early date of the this year's meeting, as well as conflicts with other local and national meetings apparently tended to restrict attendance.

MEDICARE REJECTIONS

Hospitals and Nursing Homes throughout the State have begun to experience rejections (after the fact) of payment for care rendered to Medicare beneficiaries.

The determinations are based upon the claim that skilled care was not required based on the patient's condition.

The Faculty's officers met with Hospital Council executives to discuss a proposed course of action. Initially, an audience is being requested with the Maryland Congressional delegation to discuss this and related problems.

As indicated by President Henry A. Briele, MD, the federal government is attempting to "put on the brakes" because of soaring Medicare costs. This is all at the expense of the doctor, hospital, and patient, who is the final sufferer, he indicated.

PEER REVIEW ACTIVITY

With the adoption of a Bylaw amendment by the House of Delegates, the ad hoc Peer Review Committee was officially established. This committee has been charged with the development of guidelines for use by third party payors, physicians, hospital utilization review committees, and others. Its recommendations will be forthcoming in the near future.

SEMIANNUAL SESSION

The Faculty's Semiannual Session, September 10, 11, 12, is being held at the Hotel Hershey, Hershey, Pa. Hotel reservation requests should be sent directly to the hotel as soon as possible.

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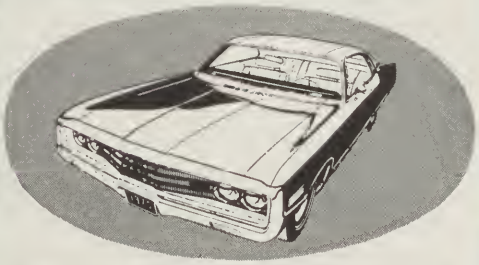
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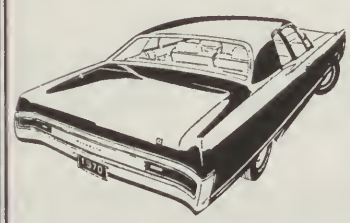
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THE NATIONAL DRUG COMPANY
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PHILADELPHIA, PENNSYLVANIA 1914

Frederick County Medical Society

Ernest A. Dettbarn, MD
Journal Representative

The February meeting of the Frederick County Medical Society, held at the Fredericktown Inn (following the specialty of the house—lobster tails stuffed with crabmeat), was devoted to formulating goals for the coming year.

Traditionally, the meetings have focused upon medical education of the members with guest speakers bringing the knowledge of their specialties to the group. Although recognizing the importance of continuing medical education, the members present were in general agreement that the local Frederick Memorial Hospital Postgraduate Program serves so well in this respect that the component society should direct its goals more in the direction of community-related programs. With this in mind, the following commitments were made:

The members of the society decided to become more actively involved in supporting the program of the American Red Cross Blood Program by pledging blood donations from individual members and lending any other necessary support on an ongoing basis.

The society's president, A. M. Powell, Jr., MD, informed the members present of a request by the Frederick County Ambulance and Rescue Service for one of the physicians to serve as a member of the Board of Directors of that organization. R. R. Roberts, MD, an orthopedic surgeon, was elected to this office from the membership. To lend support to this work, a special committee was named with Dr. Roberts as chairman, and John Harvey, MD, orthopedic surgeon; George Smith, MD, internist; and Thurman Mott, MD, psychiatrist and chief of staff of Frederick Memorial Hospital, as committee members.

A Physician Procurement Committee was established by the society consisting of George Smith, MD, chairman, and Frank Damazo, MD, Rex Martin, MD, Robert Pilgram, MD, and A. A. Pearre, Sr., MD. The purpose of this committee will be to work with various communities in the county to obtain the services of physicians. A committee was established at the February meeting with John Harvey, MD, as chairman, to work in cooperation with the Physician Procurement Committee, but especially to study the use of present facilities and innovations which may improve health care in Frederick County.

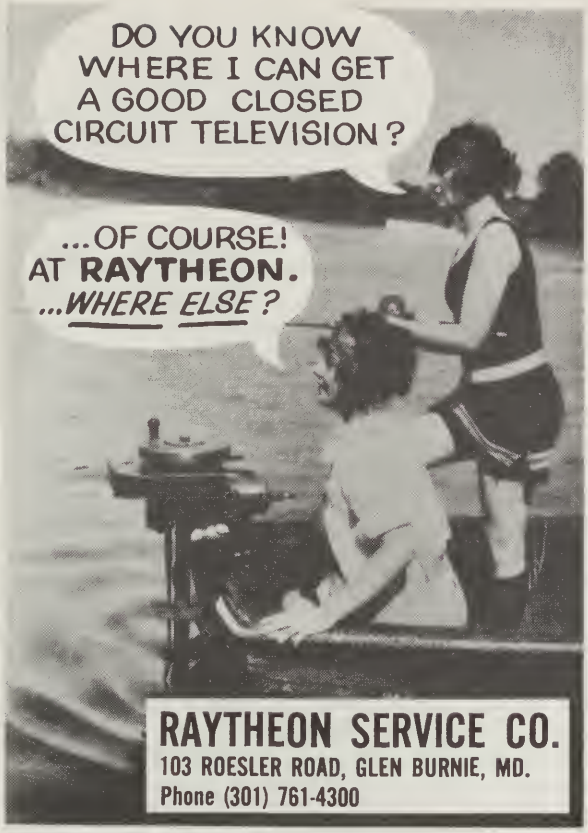
The past two or three years have seen a marked increase in schools introducing contact sports in their athletic programs. With the increased number of students participating in these athletic events, and the increased responsibility placed upon the limited number of physicians in the county, it was decided to make this one of the major focal areas of the society, and to make every effort through the society representative to the School Health Council, Charles Wright, MD, to work on guidelines.

Recognizing the need for continued service to the community, the society considered future programs concerned with environmental health, drug abuse, alcoholism, and family planning.

The members of the Frederick County Medical Society joined in mourning the passing of one of their respected colleagues and a past president of the society, Melvin E. Lea, MD. Although known mainly for his work as a general surgeon, he was also held in highest regard in the county for his work in many community activities. His passing represents a great loss to Frederick County.

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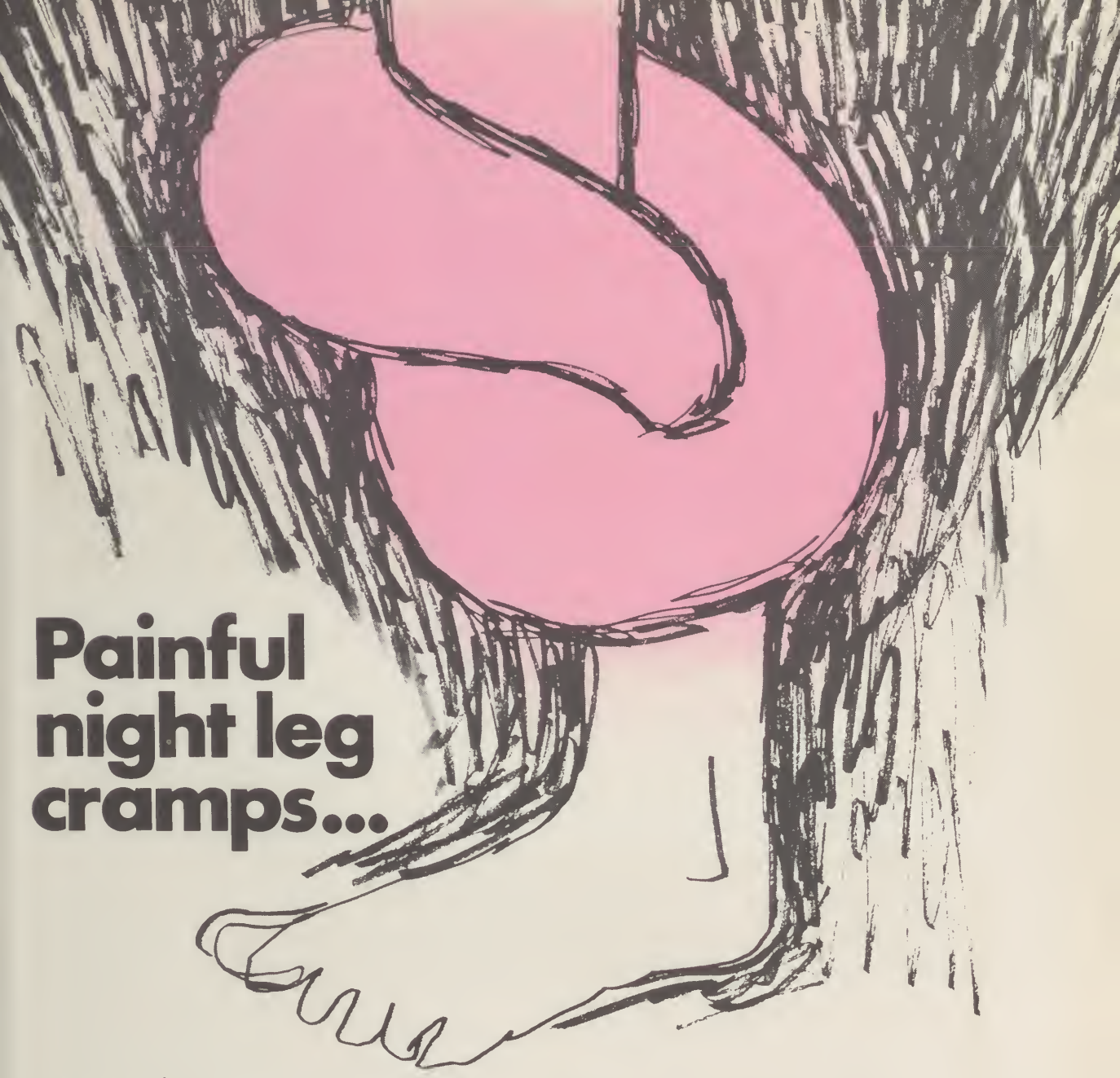
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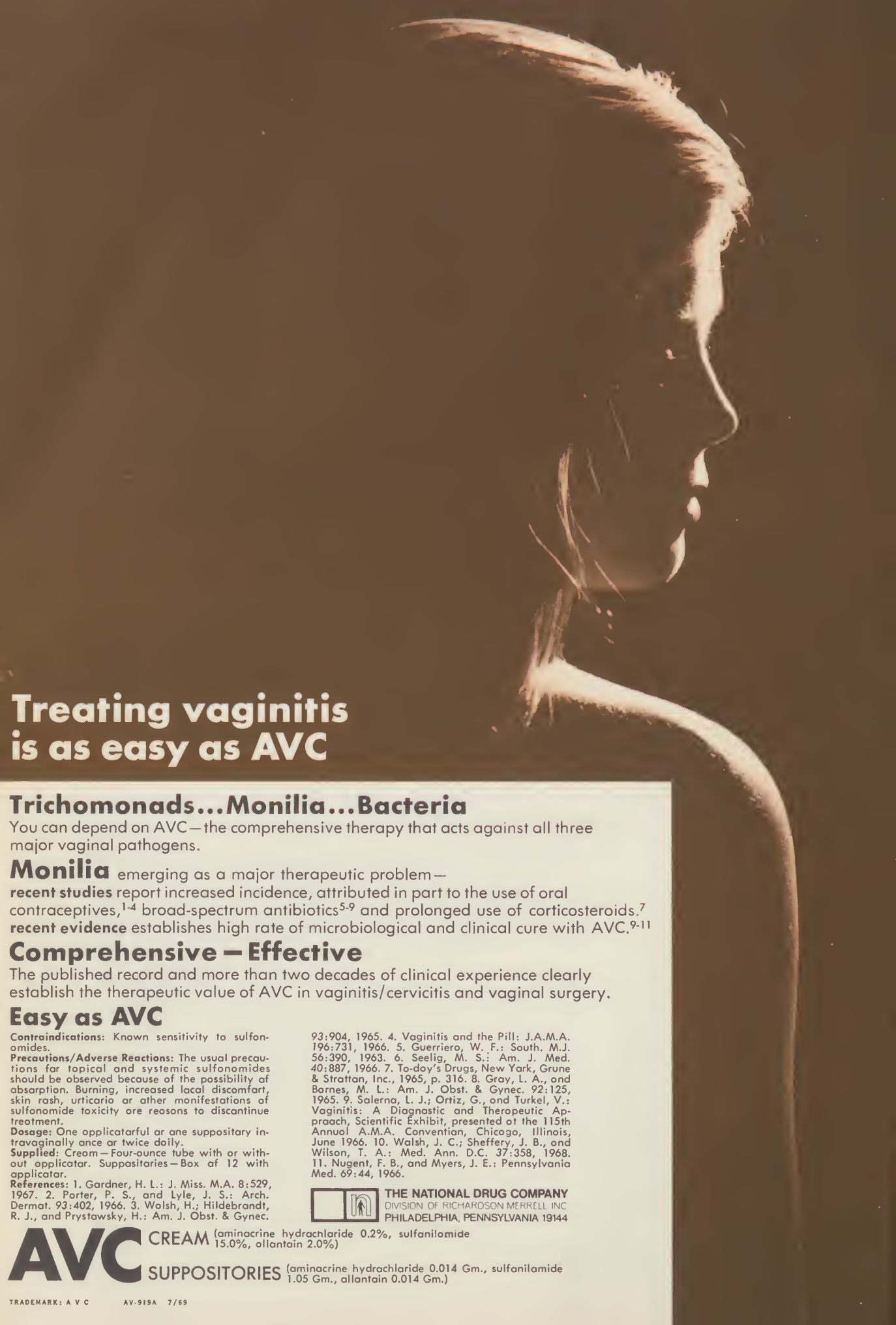
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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Wolsh, H.; Hildebrandt, R. J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-doy's Drugs, New Yark, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., ond Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., ond Turkel, V.: Vaginitis: A Diagnastic and Theropeutic Appraach, Scientific Exhibit, presented ot the 115th Annuol A.M.A. Conventian, Chicogo, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., ond Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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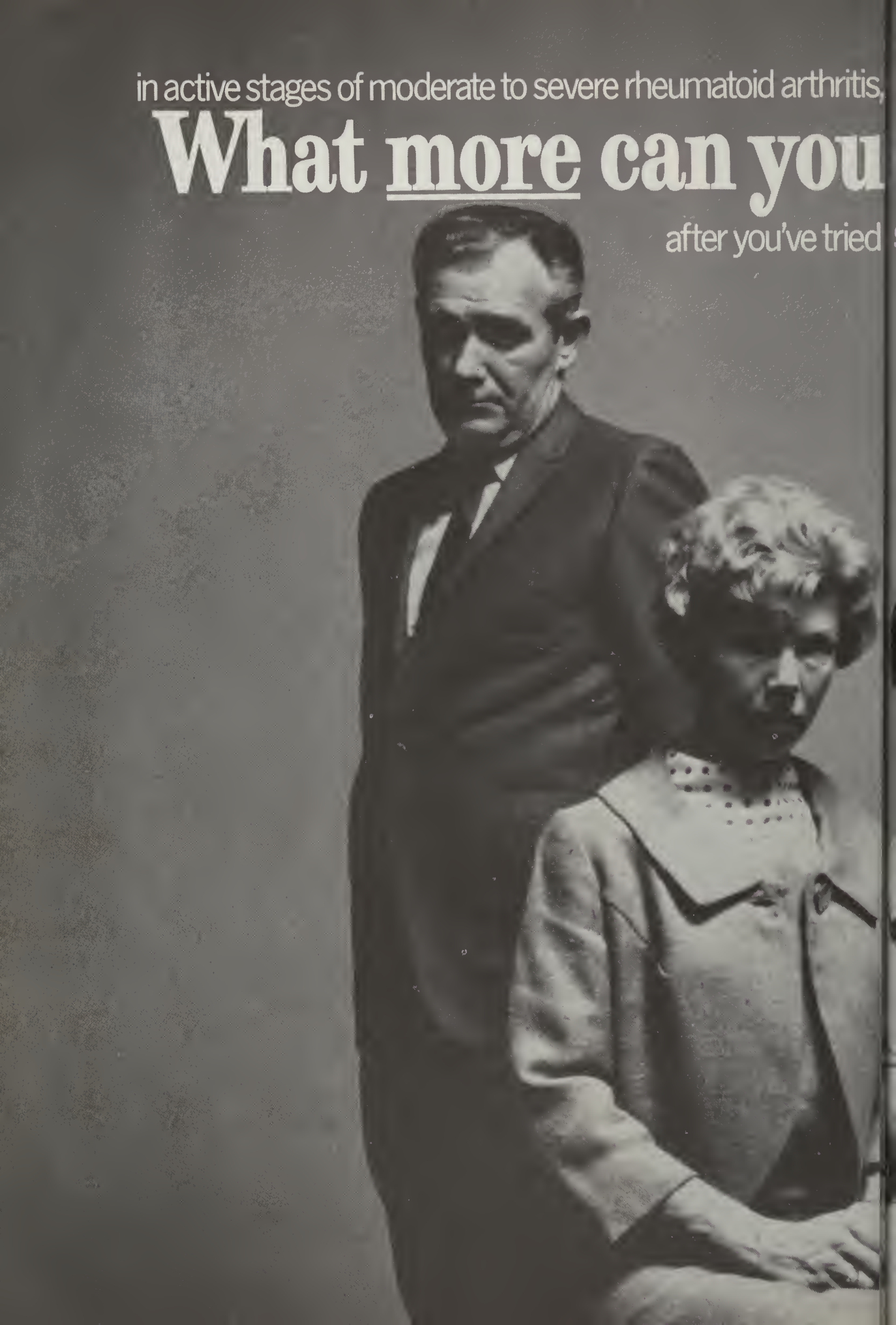
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Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin and indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.
Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.
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Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

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Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.
Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.
Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.
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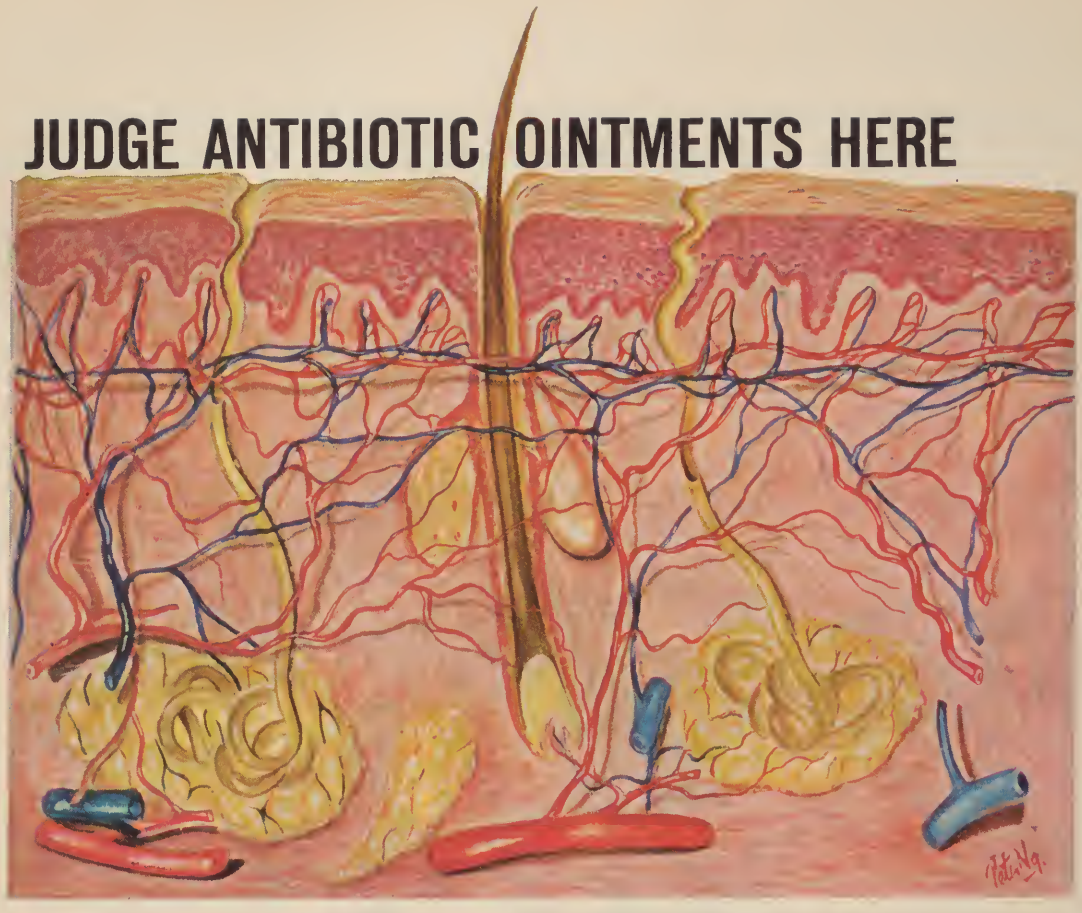
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phenmetrazine hydrochloride
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prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

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Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

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One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

•Among persons 20% or more overweight as compared with median weight for persons of like height and sex.

1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., In: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

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Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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Maryland Association of Medical Assistants

The Maryland Association of Medical Assistants held its tenth anniversary meeting on April 4, 1970 at the Holiday Inn in downtown Baltimore.

The annual meeting began at 10:00 AM with registration. Following the business meeting, "Case In Point", a film presented by the Wyeth Company, was shown. The film deals with the numerous medical-legal problems that confront medical assistants and physicians in their daily routine of medical practice.

After the luncheon break, Russell S. Fisher, MD, President of the Medical and Chirurgical Faculty, delivered the welcoming address. Then, Mrs. Ruth Dize, President of the American Association of Medical Assistants, presented the membership with the "Value of Certification". Following Mrs. Dize's address, Raymond M. Atkins, MD, advisor to the Maryland Association of Medical Assistants, introduced William DeMario, MD, Assistant Dean at Duke University in Durham, North Carolina. Dr. DeMario spoke on the advancement of the paramedical centers in hospitals and clinics.

At 3:00 PM, the results of the elections for the new state officers were announced. Coffee was then served and door prizes were distributed.

Ronald N. Kornblum, MD, addressed the gathering and presented the "Green Rebellion", which deals with the startling abuse of drugs. Dr. Kornblum showed slides which illustrated many postmortem findings of the effects of an overdose of drugs. Dr. Kornblum is an Assistant Medical Examiner for the State of Maryland.

The gala evening began at 7:00 PM with cocktails, followed by a banquet at 8:00 PM. Dr. Russell S. Fisher was the Master of Ceremonies for the evening. Rev. Thomas Subock, a Methodist minister, gave the invocation. Following dinner, Mrs. Ruth Dize and Mrs. Nell Chaney, Past-president of MAMA, installed the newly-elected officers.

On Sunday, April 5, 1970, at the Holiday Inn, a brunch was held courtesy of Raymond K. Tongue & Co. The drawing was held for the raffle, and then a tour of the U.S.S. Constellation was taken.

The week of festivities highlighted and initiated the start of Medical Assistants Week, proclaimed by Governor Mandel for April 6-12.

The association participated in Medical Assistants Week by helping with the exhibits, coffee booth, and health evaluation tests at the Alcazar during the Medical and Chirurgical Faculty of Maryland's Annual Meeting April 1-3, 1970.

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Contraindications: Thyrotoxicosis, acute myocardial infarction.

Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

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"BJove, Holmes, that amazing intuition of yours has proved right agn. What we're looking for is a single entity. I thought we were deing with several others—even twins. But now—I'd say we've unvered a double agent."

'Tl me more, Watson, and be quick about it!"

(Wson withdraws a folded paper from inside his greatcoat, and reas aloud from it):

'T key to the whole cypher is SYNTHROID (sodium levothyrone)"...

'Sh! Watson, not so loud! You'll alert our quarry."

Wson continues): "A single entity that serves two functions."

'Amaster stroke, Watson."

'Flow along, Holmes. In the neighborhood of 95% of the circulatng hyroid hormone is levothyroxine—T_4 as you call it. T_4 is bound o yroxine-binding proteins in the serum. It becomes available only gradually to tissue cells—as free thyroxine."

"Is that why there's such a smooth, predictable response, Watson?"

"Quite! With agent T_4, SYNTHROID, the chances of a precipitous rise in metabolic rate are lessened."

"But how does 'free' thyroxine fit into the picture?"

"Well, Holmes, you might call it the tissue thyroid hormone—because 'free' thyroxine (that is, thyroxine not bound to protein) is active at the tissue level. It is gradually released from thyroxine-binding proteins. Each daily dose of SYNTHROID is mostly bound to thyroid-binding proteins, and slowly released as 'free' thyroxine—the form in which it is metabolically active."

"Magnificent, Watson! So protein-bound thyroxine is the major form of circulating thyroid hormone, and it is released as 'free' thyroxine. And that's why SYNTHROID is able to simulate the normal process so artfully. Q.E.D."

"Not so fast, Holmes. SYNTHROID works for the *physician*, too. Because its dosage is more precisely controllable, and because response is so smooth and predictable, the *doctor* gets fewer phone calls in the wee hours from agitated patients. Both parties get more sleep!"

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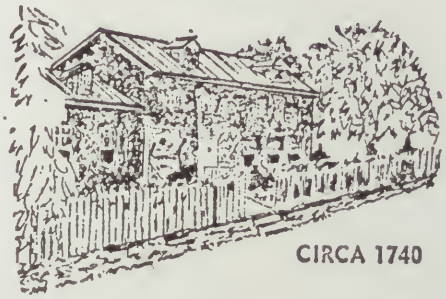
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THE MONTH IN WASHINGTON

The Nixon Administration called for limitations on medicare and medicaid reimbursements to physicians and hospitals.

Health, Education and Welfare Under Secretary John G. Veneman told the Senate Finance Committee that because of rising costs "it is now time to make some fundamental changes in the law which governs medicare and medicaid reimbursements". He said the reasonable cost and reasonable charge criteria in the medicare law had not provided opportunity for major cost-control efforts.

"We need an incentive system of institutional reimbursement and we need changes in the law that will help control the increases in the amount that the medicare program will recognize in the charges of individual practitioners . . .

"I believe . . . that the law should be changed so as to limit further the rate at which increases in physicians' fees would be recognized by medicare. The basic difficulty at present is that despite the improvements which have been made in applying reasonable charge guidelines, the best that can be done under present law is to introduce a lag in the recognition of fee increases. . . .

"Customary and prevailing charges under the program and the fees recognized by the carriers under comparable circumstances in their own business reflect, in the long run and after a suitable lag in recognition of fee increases, whatever physicians choose to charge the public generally in a market where growing demand is pressing increasingly on the limited supply of health personnel.

"Reliance on Blue Shield fee schedules as the limiting factor in medicare reimbursement, as suggested in the Senate Finance Committee staff report, however, would not seem to us to have long-run viability. Tying payments under a program as large as medicare to Blue Shield schedules would surely exert a major upward pressure on those schedules. . . .

"We believe that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to an index.

"Under such an approach, allowable charges recognized for medicare would next year be generally limited to either presently recognized charges or to a new prevailing level set at the 75th percentile of 1969 average customary charges for a given service in an area. In the future the prevailing charge screen would move upward only in proportion to increases in an index made up of pertinent portions of wage and price indices. Under such an approach, recognition of fee increases would continue, but only in relation to things that are happening in other parts of the economy and that have a bearing on the physician's cost of doing business."

The American Medical Association said that any proposal for further limitations on physicians' fees under the government programs would be unwise.

"For all practical purposes, a freeze on physicians' fees under the two federal programs has been in effect for more than a year and has proven to be ineffective," Gerald D. Dorman, MD, AMA President, said. "The costs of the program have continued to rise in spite of the freeze.

"Physicians are disturbed by threats of additional federal controls.

"Burdening these busy doctors with more red tape and restricting payments to unrealistically low levels may drive them away from participating in Medicare and Medicaid. Then the government will have discriminated against many people who need medical care. . . .

"The national interests would be better served if everyone joined with the American Medical Association in its efforts to provide more physicians."

In a later report, The Nixon Administration proposed that prepaid, closed-panel group practice health care be authorized under both medicare and medicaid.

The American Medical Association recommended to the House Ways and Means Committee a new medicaid plan utilizing existing private health insurance mechanisms to replace the present program of health care assistance for the medically indigent.

Robert H. Finch, secretary of Health, Education and Welfare, said Congress would be asked to approve legislation authorizing "health maintenance contracts guaranteeing health services for the elderly and the

poor at a single fixed annual rate for each person served.

"In the case of medicare," Finch said, "the patient will be entitled, under such a contract, to all of the usual medicare services plus preventive services. The contract price will be negotiated in advance at an amount less than the Social Security Administration presently pays for conventional medicare benefits in the locality.

"Similarly, under medicaid we are seeking authority for the states to offer to the poor the option of securing services under such health maintenance contracts. We propose to work with the individual states toward the modification of their present programs in this regard and to encourage their use of the experimental authority previously mentioned for the testing of a variety of different contractual arrangements.

"The cornerstone of this new option in federal health purchasing will be the opportunity for consumers to choose between alternatives. The ultimate goal will be to give every beneficiary of these programs a choice between obtaining services from a health maintenance organization or arranging for them in the usual way from individual physicians and hospitals. He will have the choice of withdrawing from enrollment in a health maintenance organization if he finds the service unsatisfactory. The government will have the choice of entering into arrangements with individual health maintenance organizations, subject to special standards including assurance that every contractor will serve persons of high medical risk as well as the healthy."

Earlier, HEW Under Secretary John G. Veneman told the House committee that it was planned to call the new approach under medicare Part C—to provide all services covered under Parts A and B "plus preventive services." He estimated a saving of about $15 per person, but some committee members were skeptical that more services could be provided at less cost.

Both Finch and Veneman made it clear that one of the main objectives is a fundamental change in the nation's system of health care delivery. They said states would ask to repeal existing laws restricting prepaid group practice. They said that future federal medicaid funds might be made contingent on states eliminating "legal barriers to all forms of health delivery organizations".

"Let me conclude by saying that our broad objective is to frame an effective and reasonable approach to meet the health needs of the American people," Veneman said. "Obviously, the federal government by itself cannot redirect the total health delivery system. We can, however, do our best to make sure that the vast expenditures of the federal government in the health care industry are used in a way that will contribute to the evolution of an improved, more effective, more economical system to deliver health care to our people. To the extent we are successful, we will be delivering the maximum benefit from the public funds entrusted to us. But what is equally important, we will be providing valuable support for improvement of the total health care system, public and private. In that way, we will be helping to improve the delivery of health services for all the American people."

Russell B. Roth, MD, Speaker of the AMA House of Delegates, told the House committee that medicaid "has demonstrated some weaknesses which badly need correction".

A new program, he said, should● "provide the Congress with a basis for reasonable predictable costs;● ease the burden on the states; ● assure total implementation;● and while maintaining a level of quality, insure that the costs of the program remain within the range of acceptability."

The program recommended by the AMA had these features:

1. Each eligible person (or family) would receive a certificate to be redeemed by a qualified health insurance company offering a health insurance policy or contract of certain basic health benefits such as hospitalization, medical care, preventive care, and diagnostic and outpatient care.

2. The premium cost for such policy or contract would be assumed by the federal government from its general revenue fund.

3. The states, freed from the expense of financing the basic costs of health care for their indigent and medically indigent residents, could provide supplementary benefits. These might include, for example, skilled nursing home care and dental services.

4. The determination that an insurance policy or contract, and the company offering same, are "qualified" would be made by a state agency which customarily has that authority. However, changes in the scope of benefits, and guidelines or standards to be used by the insurance departments in judging the company and the plan it offers, would be established by a national board appointed by the President.

5. All individuals and families below a certain level of income would be eligible to participate. A simple determination of eligibility could be made by the appropriate federal agency on the basis of income, or an even more refined criterion could be used such as tax liability. The program could require marginal needy families to participate in the expense of the premium charge by paying a small part of it, varying such participation in direct proportion to this tax liability.

6. For the lower income family there would be no deductibles and no co-insurance features.

7. To insure a high level of quality and to prevent cost escalation, the program would provide for a system of "peer review," organized and conducted in a manner to assure its success.

As to those services and charges which are within the purview of the medical profession, appropriate medical societies would be given the task of establishing a peer review mechanism that would, among other things, review individual charges and services wherever performed; review hospital and skilled nursing home admissions as to their medical necessity, and stays in hospitals and skilled nursing homes as to their continued medical necessity; and review the need for the professional services provided in the institution.

In the case of fraud or other clear intentional and gross misconduct, the peer review committee would be expected to bring charges before the appropriate licensing body.

To assist peer review committees in becoming established and in their operation, the program should provide for federal participation in the cost incurred in developing the program and its operation. To assure participation by members of the profession, those who serve on peer review committees should be held harmless from any actions or claims based on their decisions as to the necessity or quality of the services provided, or the reasonableness of the charge.

In the event that a peer review committee is not established by the appropriate medical society within a reasonable time, or although established is not functioning, the Secretary of Health, Education and Welfare, in consultation with the medical society, would be empowered to appoint a committee to so act.

* * *

The American Medical Association supports the Nixon Administration's air pollution control bill (S. 3466) which would give the Department of Health, Education and Welfare power to set air quality standards for the nation.

The legislation also would provide for intensified research in air pollution and for tough enforcement procedures on the national air purity standards.

The AMA also supports accompanying legislation providing for expanded research on ways to cut auto exhaust pollution and for pollution control standards for watercraft and airplanes.

James M. Blake, MD, a member of the AMA's Council on Legislation, told the Senate Subcommittee on Air and Water Pollution:

"For too long we have taken for granted the atmosphere, one of our natural resources; it is time now to look upon this resource as one on which the survival of man depends. . . .

"In recent years, the country has awakened to the need to control air pollution. Yet, more and more, our air becomes polluted and hazards to health increase. We must take stronger action to reverse this direction—stronger action than we have taken in the past. . . .

"It is imperative, that all elements of our society join to overcome the increasing pollution of our atmosphere. Measures which a few years ago were deemed adequate to meet the needs simply have not achieved the desired goals. New steps must be taken if we are to make any substantial headway in alleviating the problem. Accordingly, we believe that it is now necessary to provide for additional pollution controls and to make the essential financial commitment. . . ."

* * *

States must report to the Internal Revenue Service each year on total payments to providers of medicaid services under new regulations issued by the Department of Health, Education and Welfare.

Each year, states will file Internal Revenue Service Forms 1096 and 1099 giving amounts paid to physicians, dentists, pharmacists, opticians, nursing homes, hospitals and other individuals and institutions that provide service to medicaid patients.

States will be required to identify each individual provider of service by Social Security number, and partnerships and corporations by an employer identification number.

States also must establish procedures for verifying with recipients whether services billed by providers were actually received. Such verification may be made by spot checking.

* * *

President Nixon approved a $65 million increase in the Veterans Administration medical care budget to be used to improve services for wounded Vietnam war veterans.

An increase of $50 million was authorized in the VA's medical budget for fiscal 1971 and $15 million for the remainder of this fiscal year. Nixon acted after reviewing a study by Veterans Administrator Donald E. Johnson of the scope of the veterans' medical care program and the increasing difficulties it has faced in providing hospital and clinical care.

"To those who have been injured in the service of the United States we owe a special obligation," Nixon said. "I am determined that no American serviceman returning with injuries from

Vietnam will fail to receive the immediate and total medical care he requires."

The $15 million supplemental appropriation would be spent in April, May and June to clear up the excessive backlog in Vietnam veterans' dental claims and to improve the staffing of specialized medical programs, especially the spinal cord injury centers and coronary intensive care units.

The additional funds also would be used to carry out plans for taking hemodialysis units into the homes of veterans suffering from serious kidney ailments and to help meet increased costs of needed drugs and medicines.

The VA's budget request already submitted to Congress for the 1971 fiscal year beginning in July totals $1.5 billion.

The new request for $50 million will bring the budget for fiscal 1971 to $210 million more than the approved appropriation for fiscal 1970.

* * *

The National Society for Medical Research said that no valid finding on the effects of marijuana can be expected for another two to seven years.

Science Research Society said that part of the difficulty is that there is no standard yardstick for evaluating marijuana in scientific studies. The basic weed from which marijuana is made can vary from plant to plant and from country to country, the group said.

But the Society cautioned: "Until scientifically proven results are obtained, it appears as foolhardy to smoke marijuana as it would be to take any other unknown drug or chemical agent just for kicks."

The Society said two projects are now going on in an effort to achieve scientific standardization in marijuana studies.

* * *

The federal government has negotiated new agreements with France and Turkey aimed at stemming the flow of heroin into this country.

But, in announcing the agreements, John E. Ingersoll, director of the Bureau of Narcotics and Dangerous Drugs, said the government's long-range objective in dealing with the problem is "to induce the medical community to find adequate substitutes" for opium, from which heroin is derived.

Ingersoll admitted the U.S. was asking a great deal of Turkey, where opium has been grown for centuries.

"But when you've got over 900 deaths last year from heroin, 224 of them teenagers, in one city, I think you've got a right to start hollering," he said. "There have been three deaths a day from heroin in New York city this year. It is the major cause of death for 18- to 35-year-olds in New York city."

Ingersoll estimated 80% of the 2.5 to 3 tons of heroin smuggled into the U.S. annually comes from the poppy fields of Turkey via the clandestine laboratories of France where the opium is refined into heroin.

The agreement with Turkey includes a $3 million loan approved by the agency for international development in 1968. The money is to be used partly to help the Turks substitute crops like sugar beets and sorghum for opium and partly to equip and train a 460-man narcotics police force.

The U.S. agreement with France calls for frequent meetings in Washington, D.C. and in Paris to exchange information on such matters as the known drug traffickers and trafficking routes.

France also has assigned a force of 300 police to fight narcotics internally and 30 police to combat it at the international level. Ingersoll's narcotics bureau will increase its manpower in France next year and also will engage in a crosstraining program with French police.

* * *

Congress finally approved an appropriation bill acceptable to President Nixon to provide funds for the Health, Education and Welfare and the Labor departments for the 1970 fiscal year which began last July 1.

The two departments operated under stopgap Congressional resolutions while Nixon and Congress battled over how much money the bill should provide. The President vetoed the first bill passed by Congress as inflationary, since it exceeded his budget by $1.2 billion. Congress sustained the veto but still refused to accept Nixon's original fund-cutting proposals for the two departments. The second bill totaled $19.4 billion, $680 million more than the President requested. But Nixon accepted the compromise amount when Congress added a provision authorizing him to withhold 2% of the funds.

The second bill contained $176 million in Hill-Burton hospital funds, compared with $258 million in the vetoed measure. The appropriation for health facilities, educational research, and libraries was cut from $149 million to $126 million.

Health manpower direct loan funds remained the same, $234.5 million, but an administration spokesman said that $15.5 million would probably be withheld. Other announced plans to withhold funds in the health field included:

—$6 million from $108.8 million for air pollution control;

—$6.3 million from $35.5 million for construction of community mental health centers;

—$6.3 million from $360.3 million for mental health programs;

—$8.7 million from $146.3 million for the National Institute of Arthritis and Metabolic Diseases;

—$5.7 million from $107 million for the National Institute of Neurological Diseases and Stroke;

—$1.3 million from $103.7 million for the National Institute of Allergies and Infectious Diseases;

—$10.3 million from $164.6 million for the National Institute of General Medical Sciences;

—$7 million from $76.7 million for general research and services.

* * *

The Food and Drug Administration announced plans to require that a warning leaflet be included in every package of birth control pills.

"I have come to the conclusion that the information being supplied to the patients in the case of the oral contraceptive is insufficient and that re-evaluation of our present policies is in order," FDA Commissioner Charles C. Edwards, MD, told the Senate Monopoly Subcommittee at one of its public hearings on side-effects of birth control pills.

A proposed draft of the warning leaflet states that "there is a definite association between blood-clotting disorders and the use of the oral contraceptive."

It emphasizes the importance of reporting any side-effects to "your doctor."

"All of the oral contraceptive pills are highly effective for preventing pregnancy, when taken according to the approved directions," the proposed draft says. "Your doctor has taken your medical history and has given you a careful physical examination. He has discussed with you the risks of oral contraceptives and has decided that you can take this drug safely.

"This leaflet is your reminder of what your doctor has told you. Keep it handy and talk to him if you are experiencing any of the conditions you find described . . .

"Besides women who have or who have had blood clots, other women who should not use oral contraceptives are those who have serious liver disease, cancer of the breast or certain other cancers and vaginal bleeding of unknown cause.

"If you have heart or kidney disease, asthma, high blood pressure, diabetes, epilepsy, fibroids of the uterus, migraine headaches, or if you have any problems with mental depression, your doctor has indicated you need special supervision while taking oral contraceptives.

"Even if you don't have special problems, he will want to see you regularly to check your blood pressure, examine your breasts and make certain other tests."

An American Medical Association spokesman questioned the tone of the language of the FDA's draft of the leaflet.

"In general, it is a good idea to have a package insert but the text of the FDA proposal raises serious questions about the relationship between doctor and patient," he said. "It puts the full responsibility on the physician, but oral contraceptives generally are prescribed more as a convenience to a patient than as a medication. The patient must share responsibility both morally and legally and be alerted to her own responsibility."

The FDA now requires that pharmaceutical manufacturers only warn physicians and pharmacists of side-effects and possible hazards of taking birth control pills. Makers of the drugs were given an opportunity to comment on the proposed leaflet after its publication in the Federal Register.

* * *

Identical bills designed to increase the number of physicians and allied health personnel in family medicine have been introduced in the House and Senate. Sponsors of the legislation say that prospects are good for Congressional approval this year.

The legislation would authorize $50 million for the current fiscal year of 1971, $75 million for fiscal 1972, and $100 million for each of the next fiscal years for grants to medical schools and hospitals. The grants would help medical schools and hospitals establish departments and programs in family practice of medicine and encourage the training of allied health personnel in that field of medicine.

Sen. Ralph W. Yarborough (D.-Tex.) sponsored the legislation (S. 3418) in the Senate. Thirty-one other senators, both Democrats and Republicans, were co-signers of the bill. Yarborough is chairman of both the Senate Labor and Public Welfare Committee and the Subcommittee on Health which will handle the legislation. An aide said the senator would schedule hearings and that he was confident the Senate would approve the legislation this year.

Rep. Fred B. Rooney (D.-Pa.) introduced the bill (H.R. 15793)in the House first this year. Rooney is a member of the House Interstate and Foreign Commerce Committee which will handle the legislation on that side of the capitol. Several other House members also introduced it separately.

Aides to both Yarborough and Rooney said they had worked with representatives of the American Academy of General Practice in drafting the legislation.

* * *

ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Board of Directors Meet

The Board of Directors of the Baltimore City Medical Society met on Tuesday, March 10, 1970 at 4:30 PM at 1211 Cathedral Street, Baltimore. The meeting was called to order by John N. Classen, MD, and the minutes of the February 10, 1970 meeting were approved.

The first item on the agenda was a review of resolutions to be proposed at the Med-Chi House of Delegates meeting during Annual Meeting in April. Resolution 1A/70 submitted on August 12 by 31 members of the Baltimore City Medical Society concerns the provision of ambulatory diagnostic benefits by insurance carriers either in the hospital or in private physician offices. After some discussion, the Board recommended that this resolution, as amended by the Med-Chi Reference Committee, be adopted.

Resolution 2A/70 submitted on February 24 by 31 members of the Baltimore City Medical Society urges the Medical and Chirurgical Faculty to recommend to the Boards of Trustees and Medical Executive Committees of all Maryland hospitals that action be taken to discontinue the sale of cigarettes and tobacco in their respective institutions. The Board agreed that the implementation of such a resolution would indeed be difficult but, nonetheless, in view of evidence offered with regard to cigarette smoking and health, such a resolution seems justifiable.

The Board also recommended adoption of Resolution 3A/70, introduced by the Garrett County Medical Society, endorsing the purpose and intent of Article 43-B establishing the comprehensive Drug Abuse Control and Rehabilitation Act and urging implementation and execution of the provisions thereof.

As is required by the Bylaws, a joint meeting of the Board of Directors and the Baltimore City Medical Society Delegates and Alternates to the Medical and Chirurgical Faculty House of Delegates was then held. The Board's opinions and views were expressed by Dr. Classen to those present.

The regular meeting of the Board was then resumed and a request for endorsement of the Maryland Artificial Kidney Treatment Fund was considered. After discussion, the Board decided that recognition of this fund could not be granted until more information concerning the organization was obtained.

A letter of intent to be sent to the Office of Economic Opportunity concerning the MUND project was presented to the Board for its suggestions and endorsement. The letter was directed to Robert L. Kalinowski, MD, Deputy Associate Director for Health Affairs, Office of Economic Opportunity, Washington, D.C. The important context of this letter is as follows:

"It is the intention of the MUND Neighborhood Development Corporation (NDC) in what is expected will be a joint venture with the University of Maryland School of Medicine, Provident Hospital and/or Mercy Hospital and/or Maryland General Hospital, and private physicians serving the areas, to apply to OEO for a planning and operational grant to provide comprehensive health care for the residents of MUND.

"The essential elements of this proposal are:

"1. MUND'S NDC will represent a typical inner-city area of 19,000 people and would plan and operate with its joint venturers, the MUND Comprehensive Health Care Center. Responsibility for authority, direction, and control of the Center would rest with MUND'S Neighborhood Development Corporation.

"2. The University of Maryland School of Medicine, a regional resource, in conjunction with NDC, would serve as a coordinating point in planning, staffing, and operating the Center.

"3. Private physicians serving the area would participate in planning, staffing, and operating the Center.

"4. Provident Hospital, Maryland General Hospital, and Mercy Hospital would assist in planning, and one or more of them would help to operate the Center and to provide back-up services.

"5. The Greater Baltimore Committee and/or other qualified consultants would be engaged to serve as catalysts and to assist in the planning.

"6. A task force of representatives of the above professional institutions, private doctors serving the area, MUND-NDC, and consultants would be established to plan a system, organization, and facility to deliver comprehensive health care to MUND residents.

"A comprehensive health service center located in MUND would insure adequate health services to 19,000 people not now available to them. Good health is essential if citizens in the MUND community are to adequately participate in the planning and implementation of programs designed to lift the total community out of the morass of urban poverty. Indeed, a key objective of the total program is the establishment and operation of the MUND Comprehensive Health Care Center."

After some discussion, the Board decided that the opinions of the practicing physicians in the MUND area would be solicited and the Board would base its recommendation on these opinions.

Requests for waiver of dues from Jesus M. Lopez, MD, who, at present, is working for the World Health Organization in Latin America, and Leon Gordis, MD, who is presently a visiting professor in Israel, were approved.

The Board voted to recommend that the Medical and Chirurgical Faculty grant Emeritus Membership to William S. Stone, MD. Dr. Stone has been a member of the Society since 1955 and served as Dean of the University of Maryland School of Medicine until 1969.

The Board chose to honor a request from the U.S. Treasury Department to enclose a flyer in a forthcoming mailing concerning the purchase of U. S. Savings Bonds.

A request from the National Foundation-March of Dimes to enclose a letter with the next general mailing of the Society was denied. It was the Board's opinion that this might set a precedent and the Society would be deluged with similar requests all of which could not be honored.

The next item on the agenda was the consideration of a request from the Medical and Chirurgical Faculty of the State of Maryland as to whether the Baltimore City Medical Society wishes to investigate charges against two members of the Society concerning narcotics violations. The Board decided that certainly it felt the Society has an obligation to investigate matters concerned with morals and ethics of its membership, but that since the limitations of such an investigation are not clearly defined, the Society should query the state medical society further as to its exact position in such an investigation.

The Board concurred in the suggestion that the Bylaws be amended making the Finance Committee a standing committee with specific responsibilities, but that final authority for all financial matters of the Society should rest with the Board.

No new business was presented and the meeting was adjourned at 6:00 PM.

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Doctors Take Note . . .

(Continued from page 6)

JUNE 8-13, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course—Clinical Cytology: Portland, Oregon. Contact: American Society of Clinical Pathologists, Committee on Continuing Education, 710 S. Wolcott Avenue, Chicago, Ill. 60602.

JUNE 8-JULY 3, 1970
SPECIAL TRAINING DIVISION, OAK RIDGE ASSOCIATED UNIVERSITIES

Course—Radioisotopes in Research: Oak Ridge, Tennessee. This course is conducted by the Division for the U.S. Atomic Energy Commission. For an application and further information, write: Special Training Division, Oak Ridge Associated Universities, P.O. Box 117, Oak Ridge, Tenn. 37830.

JUNE 9-12 ,1970
THE CATHOLIC HOSPITAL ASSOCIATION

55th Annual Convention: Convention Center, Cincinnati, Ohio. The theme is "Expectation-Sensitivity-Involvement". For information, write: Convention Coordinator, The Catholic Hospital Association, 1438 South Grand Boulevard, St. Louis, Missouri 63104.

JUNE 12-13, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Postgraduate Course in Culdoscopy: New York, N.Y. The course will include didactic lectures and operative clinics and is limited to board certified and board eligible obstetricians and gynecologists. Write: H. L. Riva, MD, 40 Highland Avenue, Short Hills, New Jersey 07078.

JUNE 15-17, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Cardiac Auscultation: New York University School of Medicine, New York, New York. Director: J. Scott Butterworth, MD, FACP. Write: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 15-17, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Blood Transfusion Therapy and Related Immunology: Michigan State University, East Lansing, Michigan. Director: Scott N. Swisher, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 16-19, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course—Obstetrics and Gynecology for the Specialist: Honolulu, Hawaii. Contact: University of Hawaii School of Medicine, 3675 Kilauea Ave., Honolulu, Hawaii 96816.

JUNE 17, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Symposium—Perspectives in Human Sexuality: Montclair State College, Montclair, New Jersey. Contact: Charity E. Runden, MD, Executive Director, Montclair State College, Upper Montclair, N.J. 07043.

JULY OR SEPTEMBER, 1970
DIVISION OF MATERNAL AND CHILD HEALTH, UNIVERSITY OF CALIFORNIA SCHOOL OF PUBLIC HEALTH

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SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

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Be sure that statistics are consistent in both tables and text.

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Actions—Ovulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Ovulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Ovulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis and pulmonary embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable. Retrospective studies in Great Britain and the United States have shown a statistically significant association between cerebral thrombosis and embolism and the use of oral contraceptives.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Ovulen. Therefore, if such tests are abnormal in a patient taking Ovulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives.

The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Ovulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Ovulen may mask the onset of the climacteric. The pathologist should be advised of Ovulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

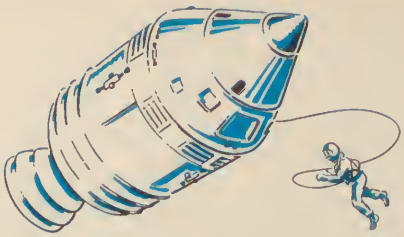
The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651:657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.



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Cutting Golf Balls:

Eye Hazard for Kids

Several news reports came into the National Society for the Prevention of Blindness last summer dealing with eye injuries caused by golf balls which explode when youngsters cut them open to see what's inside. The danger is in the liquid core of the ball, which can explode when cut into because it is under pressure of up to 2,500 pounds per square inch.

Adding to this impact force (eight youngsters with "serious eye injuries" from exploding balls were recently reported by a group of Philadelphia ophthalmologists) is the chemical harm which may occur, depending on the ingredient used for the liquid core. The substance used for ball cores varies with the manufacturer, and the list of possible ingredients encountered in reports received by NSPB includes sulfuric acid, barium salts, zinc sulfide, silicone, gelatin, corn syrup, ethylene glycol, lead oxide paste, mineral oil, sodium hydroxide, castor oil and water. Some of the more exotic ingredients reported included wheat germ and fish oil.

A spokesman for one large manufacturer of golf balls said that: "Liquid center golf balls bearing our name utilize only water." He went on to say that water was preferable because, "without any type of additive, it affords consistent reaction on impact and . . . consistency in the product offered to the public." Liquid centers (varying from water to pastes) are now the "preferred" core substance for golf balls, and have been in use since the early 1930's.

Materials and Construction

The U.S. Golf Association has set standards for minimum diameter, maximum weight and maximum velocity of golf balls. They do not "approve" or "recommend" any brands; but manufacturers meeting these standards are allowed to so state in their promotions. The Association does *not* involve itself in any way with the proportions of materials used in ball construction, or with the materials themselves.

A golf ball is composed of four main parts: the core substance (probably liquid) encased in a rubber shell; a rubber-thread winding; the cover, usually of balata, a rubber-like substance from trees in South America, and usually in combination with synthetics; and a finish, which provides gloss and protection.

According to a major manufacturer's sales manual, the liquid center, in a thin-walled seamless rubber shell, has the desirable quality of "immediate response" to the impact of the club, and transmits "all the power" to the winding. The rubber-thread winding must be high quality ("great tensile strength"), the "proper" quantity, and precision wound for maximum "fight back" reaction, distance and speed.

The manual also states, "the less expensive the ball, the less winding . . . the center is larger. . . ."

The Problem

If liquid centers are the most desirable center—for ball performance, and several of the major manufacturers believe water to be the optimum liquid—it would at least eliminate the chemical dangers to the eye if water were used in all balls.

As to the danger of the exploding centers, upon cutting into a ball, it would appear that a major part of the problem may arise from the "less expensive" balls which have larger centers and less rubber-thread winding. A youngster cutting into the ball may cut right through the winding, releasing the liquid. If the winding is thicker, this is less likely, and the youngster will probably just be satisfied with the rubber-thread ball he discovers under the cover.

In any case, NSPB's point is to make the golfing public aware of the danger to curious youngsters. The best bet would be to keep golf balls away from children; and *not* give them old balls to play with. Of course, any child who suffers an eye injury from exploding fluid of a cut-open ball should be taken to an ophthalmologist or other physician promptly. Immediate measures: flush the eye profusely with water.

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Medical Advisory Board —

In 1947, the Commissioner of Motor Vehicles of the State of Maryland instituted a Medical Advisory Board to evaluate medical conditions which could be a hazard in driving. The Board makes recommendations to the Commissioner, but has no power to act. Questions are referred from courts, license reviewers, letters received or drivers reporting a medical or mental condition which could be hazardous. In the 23 years the Board has been in operation, the Board's judgments have always been supported by the various Commissioners. Reports are obtained from the individual's physicians, hospitals, clinics, employers when indicated, agencies, courts, and schools. When conflicting information has been obtained, the Department also has investigators who, on request, will question neighbors, employers, store personnel, and family.

The reports are reviewed by the Medical Advisory Board members and the individuals may be requested to appear before the Board. This could be because the reports indicate a possible definite hazard or a hazard could exist if the individual did not understand his medical condition in relation to driving or take proper treatment. Records for the past five years indicate that approximately one fourth of the cases are rejected each year. The medical conditions are divided into eight categories according to the type of conditions seen.

"Epilepsy" includes all those cases referred for passing out, blackouts, loss of consciousness or amnesia which are not due to cardiac conditions or hypoglycemia. These applicants or drivers must be seizure free for a minimum of two years, see their physicians regularly and take their medication regularly. Should medication be decreased, then they must go at least six months without driving for each time medication has been decreased. From the chart it is evident that approximately one third are rejected. Many who were rejected one year, with improvement in their conditions, have obtained permission to drive in subsequent years.

In the category of "Mental" are all forms of mental illness from mild to severe psychotic episodes, narcotics users, and individuals who have been found guilty for the second time of driving under the influence of alcohol. Approximately one third were considered a risk. Those who have been guilty the second time of driving under the influence of alcohol must be seen by the license reviewers if the Medical Advisory Board recommendation is favorable. The license reviewers then re-evaluate his driving record and investigative report and may further deny the privilege of driving.

The next largest group seen are the "Diabetics". One tenth of those rejected are primarily the juvenile diabetics who have frequent insulin reactions, have little understanding of their disease, have had accidents or have other complicating conditions. Many of these on reapplying are given a positive recommendation if improvement is shown.

The fourth group are those with "Cardiac Disturbances". One fifth of those rejected have mainly uncompensated cardiac failure or some other severe condition associated with their cardiac disease. It is recommended that an individual not drive for at least six months after a coronary attack.

The group with "Paralytic Conditions" are composed of those with paralysis due to various causes such as stroke, cerebral palsy, polio, etc. If the condition is not a degenerative one and the individual has at least one normal functioning leg and arm, approval is recommended. Those with athetosis, cardiac involvement, arteriosclerosis or mental deterioration are rejected. Of this group, approximately one fifth are rejected. Most of these persons have severe cerebral palsy and athetosis with or without retardation or are stroke patients with mental changes.

Five Year Summary

The sixth group are those with "Atrophy or Degeneration," mainly with neuromuscular conditions. With those individuals who are expected to have exacerbations, much time is expended discussing the privilege of driving while in remission and reporting their exacerbations and not driving until approved. There has been good cooperation with these cases. Less than one third were rejected.

The seventh group is very small, but important—amputees. The amputated limbs may be the result of disease or accidents and, thus, should be evaluated. One fourth were rejected on this basis.

The last group is the "Mentally Retarded". Although some who cannot read have licenses, with the increase in cars on the road and more complex driving conditions, it has been the decision of the Board that those with IQ's under approximately 70 should not drive. This is the only group in which the rejected was the majority, but it is a very small group at present. However, the number has been increasing slightly each year.

In each case an adverse recommendation can, with significant improvement in the individual's medical condition, be reversed. In many cases, suggestions are made to the individuals as to what they should do. It is especially impressed on them to follow their physician's recommendations.

For 23 years, meetings have only been held in the State Department of Motor Vehicles building, but beginning shortly, meetings will be set up in Salisbury, Cumberland and Rockville. This will bring the meeting place closer to the physicians in the area and to the drivers. Additional areas for future meetings are also being planned.

RUTH W. BALDWIN, MD
Chairman
Medical Advisory Board
Maryland State Department of Motor Vehicles

Medical Conditions Seen by the Medical Advisory Board in the Past Five Years

ATEGORY	1964-1965			1965-1966			1966-1967			1967-1968			1968-1969			TOTAL		
	A	R	Tot.	A	R	Tot.	A	R	Tot.	A	R	Tot.	A	R	Tot.	A	R	Tot.
ilepsy	387	144	531	462	199	661	551	228	779	512	256	768	522	173	695	2434	1000	3434
ental	253	202	455	368	241	609	490	273	763	465	218	683	446	250	696	2022	1184	3206
iabetic	530	46	576	582	59	641	626	99	725	584	47	631	583	41	624	2905	292	3197
rdiac	292	84	376	216	58	274	269	78	347	199	37	236	169	49	218	1145	306	1451
ralytic	211	56	267	137	35	172	136	45	181	114	37	151	83	44	127	681	217	898
rophy or egenerate	135	109	244	139	64	203	115	66	181	69	24	93	65	32	97	523	295	818
nputated mbs	18	11	29	7	2	9	9	2	11	4	2	6	10	1	11	48	18	66
ental tardation	0	2	2	0	0	0	0	2	2	2	1	3	2	3	5	4	8	12
	1826	654	2480	1911	658	2569	2196	793	2989	1949	622	2571	1880	593	2473	9762	3320	13082

y:
= Approved
= Rejected

SEAT BELTS:

A Habit To Last A Lifetime

One of the most tragic—and most common—aspects of traffic fatality investigation is the sight of a dead victim in a smashed automobile, sitting on the belts which could have saved his life.

SUSAN P. BAKER, MPH
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The Johns Hopkins University
School of Hygiene and Public Health
Office of the Chief Medical Examiner of Maryland
Maryland Medical-Legal Foundation

Safety belts are effective. They can substantially reduce the number of highway deaths and minimize passenger injuries.[1] Nevertheless, most seat belts are not used. Although standard equipment on U.S. automobiles produced since 1964, they are used by only a third of the people who have them.[2] Even though the combined lap and torso restraint has been shown to prevent essentially all fatalities at speeds up to 60 miles per hour,[3] available upper torso restraints are apparently no more likely to be used than lap belts.[2]

Although progress is being made in the development of new protective devices such as air bags, it will be many years before all automobiles have them. Furthermore, seat belts will *still* have to be worn to prevent ejection, and to protect the passenger during rollover. Thus, automobile occupants must somehow be inspired to use those devices which may save their lives in the event of a crash.

We suggest an approach aimed at promoting more general usage of available restraint systems. Emphasis is placed upon restraints for children, in the belief that an intensive effort to protect young people could lead to more widespread use of safety restraints by passengers of all ages. At present, few children receive adequate protection when riding in automobiles. The physician with young patients is in an excellent position to launch an effective program of injury prevention.

In 1968, 180,000 passengers under 15 years of age were injured in highway crashes in the United States, and almost 3,000 were killed. Forty percent of the children who died were less than five years old.[4] These statistics reflect the tendency of most parents to allow their children to travel unrestrained, or to place them in car seats which merely provide a place to sit without offering safety.

Most collision injuries occur when unrestrained occupants are hurled by their momentum against whatever lies in their path. Depending upon the direction of impact and the sequence of events, a passenger may collide with any part of the vehicle, another passenger, the road, or objects outside the car. Furthermore, as the first of our case studies suggests, children thrown about in a collision may increase the hazard to other passengers.

Recent Maryland Cases

Case 1. In a head-on collision, a five year old who had been sitting in the back seat of the car was thrown forward with such force that his body bent the front seat. The front seat became detached and the mother, who was driving, was killed; the child sustained a crushed hip and ruptured spleen. Appropriate restraints probably would have prevented both the mother's death and the child's injuries.

Case 2. A station wagon making a left turn was struck by another car, causing the right rear door to open. A two-year-old child who had been seated near the door was thrown out onto the road. Death was due to a lacerated liver. The other four passengers were not thrown out, and received only minor injuries.

Case 3. An eight-year-old boy sustained head injuries and a broken leg when his father's car was hit on the left side—even though he was sitting in the right front seat. He died four days later without regaining consciousness. A seat belt could have kept him from striking the surfaces which injured him.

Studies of Collisions Involving Children

A medical-engineering team of accident investigators at UCLA evaluated 46 collisions in which 82 of the passengers were less than 13 years old.[5] Sixty-three of the children were injured, seven fatally. Each injury was analyzed as to its severity, the

mechanism of its production, and preventive measures which would have been effective. The team observed that infants held in the arms of their mothers were occupying the worst possible location if a collision occurred. The mother's forward motion in a frontal impact tends to crush the infant between her body and the interior of the car. Even a mother using a seat belt would find it difficult to hold onto a baby whose effective weight is greatly increased in a collision, as the baby moves toward the area of impact.[6]

In general, the UCLA group found that children younger than five were injured more severely than children in the 5 to 12 age group. Placing unrestrained children in the rear seat proved to be ineffective in preventing injuries. Because of their relatively high center of gravity, younger children tend to be "top heavy". This factor, as well as their lighter weight, causes them to become airborne more easily than older children and adults. As a result, young children riding in the back seat received more severe injuries than older children. (Iskrandt and Joliet noted that there is a year-by-year decrease from age one to four in the death rate associated with nonpedestrian motor vehicle accidents.[7] We believe that this phenomenon could be associated with the gradual decrease in the child's tendency to become airborne in a collision.)

Recommended Restraints

The age-associated changes in children's center of gravity, height-weight relationships, collision kinematic behavior, and patterns of injury make it necessary to recommend different types of restraints as a child grows. The UCLA group described the advantages and disadvantages of a number of devices. On the basis of collision injury evaluation and experimental collision research, they suggest the following:

1) From birth until four to six months, the infant should ride in a car bed which is securely anchored with seat belts and lies parallel to the long axis of the vehicle. The child should be placed in the bed with his feet toward the front of the car. His safety during a rollover would be increased if the car bed were covered with webbing or a net.

2) Between the ages of four and six months, most children can graduate to an upper- and lower-torso harness of net or wide webbing. The harness is placed on the child before he is placed in the car, then attached to webbing which is looped vertically around the back seat and attached to the rear deck and floor pan. The child can sit or lie down, or stand to stretch his legs.

3) Between 12 and 18 months, a child can start using an *acceptable* car seat. Such a seat either is attached directly to the structure of a car, or employs the standard lap belt to anchor the seat or restrain the child while he is sitting on it; wide bands of webbing or a molded plastic shield keep the upper torso from jackknifing at the time of collision. Unfortunately, the most commonly used children's car seats are hooked over the front seat with U-shaped tubes, or are inadequately attached to the seats of the car with straps or tubes. Such children's seats often come loose in a crash and provide no protection against injury. Furthermore, their narrow straps and poorly padded front-bars may actually cause injuries. (Some of the recommended seats can be used by children as young as six to nine months).

4) After the age of three or four (40 to 45 lb), the child may use a standard adult lap belt. Sitting on a *hard* cushion or folded rug will help him to see out of the windows more easily, as well as ensure that the belt will be over the pelvis rather than the abdomen. The adult shoulder-lap belt combination is *not* recommended for children until they are four to five feet tall and have a seated height of 24 to 25 in.

King, Paul, and Spitznagel [8] recommend that children weighing less than 50 lb use special children's restraints as long as possible. They urge development of restraints especially suited for the 5 to 12 year age group, but point out that lap belts do offer good protection from injuries resulting from ejection or striking the interior of the vehicle.

The Physician's Role

Clinicians should be willing to assume an active role in protecting their patients from major health hazards. Since accidents are the leading cause of death in children over a year old, their prevention is surely as important as prevention of the childhood diseases which physicians have brought under control by immunization. Burg, et al,[9] recommend that physicians should actually *prescribe* automotive restraining devices for their young patients.

There are numerous reasons for such a positive approach. In the first place, many parents automatically try to follow their physicians' instructions in matters relating to the health of their children. One study showed that although letters from the Safety Council had no effect, installation of seat belts increased among the families seen by a pediatrician who spent a few moments discussing the subject with parents.[10] Willingness to invest in the safety of their children was further demonstrated by the tendency of parents to buy an expensive car seat in preference to a cheaper one.[11]

Physicians also have an opportunity and a responsibility to advise parents *against* those "restraint" practices which are potentially dangerous. For example, many parents need to be told that a child

traveling in a wooden crib can be badly hurt when thrown against the crib, and that "papoose" style infant seats were not designed for automobile seats.[5] Car seats which hook over the seat back are not safe in a collision, yet their widespread use suggests that most parents are unaware of this.

As a young patient matures, his physician is in a position to suggest the type of restraint which is compatible with his stage of growth, just as he would suggest introduction of new foods or the appropriate immunization schedule. As noted by Burg, et al,[9] if the physician fails to recommend the proper restraint, no one else is likely to do so.

A child who is accustomed to being restrained at an early age is probably more likely to accept restraints as he grows older. Once children are old enough to reason, their acceptance of safety devices may depend upon whether other people in the car are using seat belts. A North Carolina study showed that young adult drivers were the least likely to be using seat belts and that restraints were used by a smaller proportion of females than males.[2] This is particularly unfortunate, since young mothers are in the best position to influence the safety habits of their children. If parents can be persuaded to set a good example by fastening their own seat belts, a second major achievement can be scored, since the motor vehicle death rate for adults is far greater than that for children.

Opposition to Use of Restraints

Since parents themselves often resist the use of seat belts, four of their most frequently expressed fears are given here, followed by factual counter-arguments:

1. "I would rather be 'thrown clear' if I'm in a bad crash." Occupants who are thrown from cars and escape without injury are an exception; ejection is considered the leading cause of death in highway crashes.[1]

2. "I am afraid of being trapped in a burning car." (Or, "I want to be able to escape if my car goes into a river.") If a crash is of such force that fire results, unrestrained occupants may be too disabled to remove themselves from the car. Seat belts can be released so quickly and easily that an occupant whose safety belt has kept him intact and conscious has the best chance of escaping from a burning or submerged vehicle.

3. "I have heard of people being injured by seat belts." Such injuries are uncommon, and minor when compared to the injuries which would have resulted if no seat belt had been worn. Seat belt injuries are extremely rare when belts are worn correctly—snug and low over the hips. Shoulder straps need a little slack, enough for a hand to be slipped between strap and chest.

4. "Lap belts don't offer enough protection to be worth the bother." In a series of over 8,000 crashes studied in North Carolina, severe injuries were reduced by 36% and *no* fatal injuries were sustained by any of the 985 drivers wearing lap belts.[12] Not worth the bother?

Conclusion

Marked reduction in highway fatalities and injuries can be achieved by: (1) elimination of intoxicated drivers from the highways, (2) continued improvement in vehicular design, and (3) proper use of restraint systems by all automobile occupants. The first goal apparently will not be reached in this country for many years. Continued progress in the second area will help, but only as older vehicles are "retired." The third goal is the best preventive measure currently available to the American public.

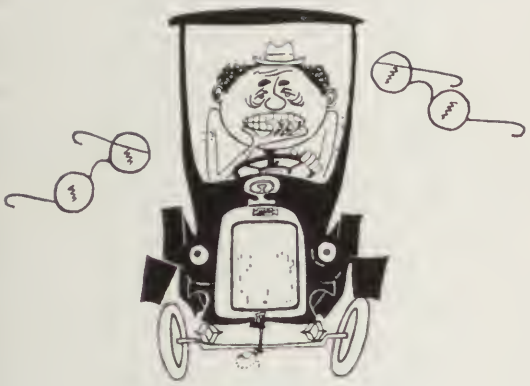
However, only one third of all adults are using their belts regularly. Even more appalling is our failure to insist that children be properly restrained. Physicians are in an excellent position to strongly influence their patients' use of seat belts.

This article describes types of restraints recommended for children of various ages. Emphasis by physicians on the use and the proper selection of restraints for children will save lives now and promote use of safety devices by our coming generation of drivers and passengers.

REFERENCES

1. Huelke, D. F., and Gikas, P. W.: Causes of Deaths in Automobile Accidents. *JAMA* **203**:98-105, March 25, 1968.
2. Council, F. M.: Seat Belts: A Follow-Up Study of Their Use Under Normal Driving Conditions. *J Safety Res* **1**:127-136, Sept 1969.
3. Bohlin, N. I.: A Statistical Analysis of 28,000 Accident Cases with Emphasis on Occupant Restraint Value. Society of Automotive Engineers, N.Y., Oct 1967.
4. Accident Facts, 1968. National Safety Council, Chicago, 1969.
5. Siegel, A. W., Nahum, A. M., and Appleby, M. R.: Injuries to Children in Automobile Collisions. 12th Stapp Car Crash Conference, Society of Automotive Engineers, N.Y., 1968, p 1-46.
6. Rose, C. W.: A Safety Engineering Approach to Child Restraining Devices. 7th Stapp Car Crash Conference, Charles C. Thomas, Springfield, Ill., 1965, p 432-436.
7. Iskrandt, A. P., and Joliet, P. V.: *Accidents and Homicide.* Harvard University Press, Cambridge, Mass. 1968.
8. King, B. G., Paul, E. C., and Spitznagel, C. R.: Children's Automobile Safety Restraints: Characteristics and Body Measurements. Society of Automotive Engineers, N.Y., 1969.
9. Burg, F. D., Diamond, E., and Siegel, A. W.: A Physician's Guide to the Prescription of Automotive Restraining Devices for Infants and Children. Third Triennial Congress on Medical and Related Aspects of Motor Vehicle Accidents, N.Y., May 29, 1969.
10. Bass, L. W., and Wilson, T. R.: The Pediatrician's Influence in Private Practice Measured by a Controlled Seat Belt Study. *Pediatrics* **34**:700-704, 1964.
11. Rogers, R. A., and Silver, J. N.: Elements of an Effective Child Restraint System. 12th Stapp Car Crash Conference. Society of Automotive Engineers, N.Y., 1968. p 172-187.
12. Campbell, B. J.: Seat Belts and Injury Reduction in 1967 North Carolina Automobile Accidents. University of North Carolina Highway Safety Research Center, Chapel Hill, N.C., 1968.

VISION and DRIVING



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Vision is almost the only route of sensory input when driving a car. Hearing plays such a minor role that many states allow completely deaf people to drive a private vehicle. On today's high-speed highways the driver is constantly pressed for quick reactions to fleeting visual stimuli. For this reason it is necessary that he be able to see well enough to avoid accidents.

Dynamic visual acuity, or the ability to identify rapidly moving objects, is the visual response most closely correlated with the crash rate.[1] Evidence collected in California [2] revealed that more than half the motor vehicle operators arrested for cutting in had one eye with subnormal acuity. This inquiry also showed that drivers with accident-free records had better vision than those with bad driving records. That good dynamic visual acuity is of vital importance in the proper interpretation of the clues needed for driving a car is indicated by the following data: At 60 miles an hour a car travels 88 feet per second. A driver with normal 20/20 vision has 3.2 seconds to clearly read a five-inch road sign and act upon this information.[3] But as a driver with:

20/30 vision he has only 2.5 seconds
20/40 vision he has only 1.6 seconds
20/50 vision he has only 1.4 seconds
20/60 vision he has only 1.0 seconds
20/100 vision he has only 0.65 of a second [2]

This does not give him much time to read and act upon the information. Because the best possible vision is none too good at the speeds we travel on modern highways, the problems with reduced vision become obvious. Larger signs would obviously also be of help.

On the basis of risk, drivers are frequently divided into classes one, two, and three.[4] Class three includes private motor vehicle operators, and classes one and two various types of commercial and professional operators, such as chauffeurs, bus, and

truck drivers. The standards are higher for these professional drivers than for class three. When evaluating a person's vision for driving, one must remember that a patient may be qualified to drive his private vehicle, but be disqualified for driving a nonprivate one such as a school bus.

Central visual acuity should be 20/40 or better in at least one eye.[5] People with optimally corrected vision of 20/70 or less in the better eye present a serious limitation and should be referred to an ophthalmologist to ascertain if their vision can be corrected. Spectacle correction of 10D or more in the better eye is disqualifying, unless a visual field of 140 degrees can be demonstrated.[4]

Breadth of vision is the ability to recognize objects in the horizontal portion of the visual field. Visual fields are obviously important for safe driving, because a driver must possess some lateral awareness in order to pass vehicles or see cars approaching from the side. Visual fields of 140° or better are considered adequate for most motor vehicle drivers except for the commercial and professional ones.[4, 5] However, the field of usable clear vision decreases as the velocity of forward motion increases. A normal field of vision is reduced to approximately 80° at 40 mph and 40° at 60 mph.[3] Increased use of larger mirrors would be helpful in increasing lateral awareness.

Because of the importance of depth perception, one-eyed drivers and spectacle-corrected aphakic drivers present increased risk of intersectional crashes. After cataract surgery the one-eyed individual, depending on the operated eye, may have a narrow visual field of only 40°.[4] Also these patients may be in advanced years, with increased difficulty with night vision and dynamic visual responses. They require special evaluation. Measurement of reaction time may be important in these older people, and can be done on special equipment at the Bureau of Motor Vehicles. A binocular-aphakic wearing contact lenses usually can drive safely.[4] Patients who have had monocular vision for years have learned to accommodate to this handicap, whereas people with recent loss of one eye have not. Therefore, people with recent or temporary loss of vision in one eye cannot drive, but those with long standing one-eye vision usually can do so.

Night blindness is difficult to measure. However, the presence of corneal opacities and retinopathy may disqualify a person for night driving.[4] Patients requiring pupillary constricting medication, as in the control of chronic glaucoma, also have limitation of night operation. Sunglasses reduce light transmission by 47% to 81%.[3] No one should wear dark glasses at night, and the windshield should not be tinted more than one third of the way from the top.[4] The need for regular bifocals *per se* is not disqualifying for any class of drivers.[4]

Color blindness has been considered as a possible cause of highway accidents. However, most traffic lights have been standardized, and it is doubtful if the usual red-green color blindness is of any importance in the cause of traffic accidents.[5] A completely color-blind individual usually has other deficiencies of his visual apparatus and these may prohibit him from driving.[5]

Until July 1, 1969, Maryland shared with Virginia the dubious distinction of having the poorest standards for visual acuity in the U.S.[6] Vision of only 20/70 in the better eye was required for driving. The new law[7] requires that a driver must have vision in each eye of at least 20/40. If he has only monocular vision, bilateral mirrors must be employed. People with recent loss of vision in one eye are prohibited from driving for 90 days.[7]

However, many people received their licenses when only 20/70 vision was required, and many may have lost their vision without any change in their driving license. The law now requires eye re-examination after age 70, or after complaint, suspension, revocation, or repeated accidents.[8] As practicing physicians and citizens interested in the health of the community we should 1) advise patients with poor vision to have their eye problems corrected, and 2) report to the Division of Motor Vehicles any person with such poor vision as might produce an accident.

Summary

Vision is virtually the only sensory input determining decisions in driving. In today's high-speed driving a motorist must be able to determine visual clues extremely rapidly. Any decrease in this dynamic visual acuity will significantly increase the likelihood of accidents. Many of the signs are too small to be easily read at high speed. We physicians should make sure that our patients have good vision before they are allowed to drive a car.

REFERENCES

1. Burg, A.: Vision and Driving: *A Summary of Research Findings*, No. 216, Highway Research Record, Washington, D.C. National Research Council, 1968, p. 1.
2. "Guiding Principles in the Medical Examination of Applicants for Motor Vehicle Driving Permits," World Health Organization, Feb. 24, 1956.
3. *Vision Screening for Driver Licensing*, A Joint Publication of the American Association of Motor Vehicle Administrators, Washington, D.C., and the Committee on Motorists Vision and Highway Safety of the American Optometric Association, 7000 Chippewa St., St. Louis, Missouri 63119, 1966.
4. "Visual Factors in Automobile Driving and Provisional Standards," AMA Committee on Medical Aspects of Automotive Safety, *Arch of Ophthal* 81:865, June, 1969.
5. "Physician's Guide for Determining Driver Limitation." AMA Committee on Medical Aspects of Automotive Safety, AMA Publication, 535 N. Dearborn St., Chicago, Ill. 60610, 1968.
6. 1967 Survey of State Requirements for Motor Vehicle Operators, American Optical Company, Southbridge, Mass.
7. House Bill No. 987, 1968 Maryland General Assembly.
8. 1969 Survey of State Requirements for Motor Vehicle Operators, American Optical Corporation, Southbridge, Mass.

There is no reason why highway loss-reduction countermeasure priorities must parallel the rank of causes. Traditional emphasis only on crash prevention ignores major opportunities for reducing losses to damaged people and property. A standard method is needed for rating vehicles' occupant protection considering limits set by physics and body force tolerances. The use of structural damage for crash energy absorption, particularly at 5 to 20 mph, is archaic in comparison with aircraft strut design. It is predicted that the present, structural-damage approach to low speed energy absorption will soon become publicly unacceptable.

Why the Issue is Loss Reduction Rather than Only Crash Prevention

Transcript of a speech delivered during the Automotive Engineering Congress of the Society of Automotive Engineers in Detroit, Michigan, January 12-16, 1970.

WILLIAM HADDON, JR., MD
President
Insurance Institute for Highway Safety



Traditional highway safety efforts have almost exclusively emphasized "accident (ie, crash) prevention" as a sufficient response to reducing highway losses in damaged people and property to the maximum feasible extent. This traditional emphasis, although important as one part of a much broader, modern approach, has for decades written off, by default and omission, many other means for substantially reducing both the human and property losses—means that have nothing to do with crash prevention *per se*. Delaying public understanding of the issues and, hence, of balanced programs of loss-reduction measures, the traditionally narrow highway safety crash-prevention approach continues to consign hosts of Americans to injury and disfigurement, and silently accepts continuing billions of dollars of unnecessary property loss.

Rare indeed, for example, has been the mention in traditional highway safety messages of the need for much better crash-packaging of vehicle occupants to protect them when they are hit, especially from the side; of the urgent need for the systematic, nationwide modification of rigid poles and of other roadside structures so that they no longer kill those who, for whatever reason, hit them; or of the need for the organization and provision of emergency services everywhere to give persons seriously injured on the highway at least the chance they would have if similarly damaged on a jungle battlefield.

The aggregate highway dead in the U. S. will, at present rates of increase, reach 2,000,000 (two million) in 1972,[1] or one man, woman, or child fatally impacted, crushed, lacerated, torn or burned to death for each two miles of the country's total street and road network.

Moreover, means for reducing the nation's astronomical bill for the repair and replacement of sheet-metal and various "crash parts" have completely failed to be noted in traditional messages and programs. (It is noteworthy also that at a time when there is accelerating recognition of ecologic problems, no mention is made of the contribution of the associated drains on both this nation's dwindling raw materials and of those of other countries whose reserves we increasingly consume far out of proportion to our percentage of the world's population.)

Furthermore, the traditional approach to the reduction of highway losses is strikingly different from, and tragically deficient in comparison with, that which mankind has long used in reducing losses in many other instances of harmful ecologic interactions between people and property and their environments. When man learned he could not always prevent ships from colliding, parcel post packages from being dropped or otherwise abused, his toes from being stubbed, or fires from igniting, he did not throw up his hands, regress into ineffectual and defensive talk of "human error", and take the position that nothing further except reforming, "controlling", or educating man could, or even should, be done. To the contrary, he beefed up the resistance of structure, he appropriately packaged that which he valued, he made his packages, themselves, rugged and inexpensive to impact—by design—and he set up fire departments and the Coast Guard. In brief, he concentrated logically and necessarily on measures of whatever type that reduced the end results *per se,* and did not talk inadequately *only* of prevention of the initiation of the untoward events themselves.

Even in dealing with losses from events such as hurricanes and earthquakes over which he had no influence, civilized man long ago largely abandoned emphasis on ideas of retribution and reform, and shifted his loss-reduction approaches to beefing up building codes and the development of modern emergency-response systems.

Nor is such concentration on preventing the end result, rather than hiding behind the excuse of human failing, a new or undisseminated idea. Some three millennia ago, the moral imperative and the practical nature of this central issue were stated incisively and without possibility of misunderstanding by the author of the eighth verse of the twenty-second chapter of Deuteronomy when he wrote: "When you build a new house, you shall make a parapet for your roof, that you may not bring the guilt of blood upon your house, if anyone fall from it."[2]

Even then, it was understood that moral guilt lies in failing to understand and anticipate, through appropriate design and other action, the variability of human behavior and the inevitability of what these days is still conveniently labeled as "human error" and "the nut behind the wheel". Viewed differently, the Biblical imperative was—as the imperative of our ecologically disrupted present must be—to make the environment as harmonious with fallible man as possible, and not to wash one's hands unless one can remake man to suit a hostile environment, especially one of man's own planning, design, and construction.

This Biblical statement implicitly recognizes another one of the scientific principles in approaching the reduction of any category of environmentally damaged people or property. This is that there is no logical reason why the priority (or rank) order of loss-reduction measures must parallel the sequence of causes, a point as yet but rarely understood. In the reduction of the epidemic paralysis of man caused by the poliomyelitis viruses, for example, attempts to reduce human ingestion of the viruses by modifying human behavior through closing theaters, schools, and swimming pools had little or no effect on reducing the losses. The countermeasure that

worked was directed at a later point in the causal sequence and involved successfully modifying the body's interaction with the viral hazard, by increasing body resistance. The electrical fuse is another of the many examples of highly successful measures that greatly reduce losses caused largely by human behavior.

Failure to recognize this fundamental distinction between the rank of causes on the one hand, and the contribution of countermeasures to loss reduction on the other, is the most persistent and tragic characteristic of traditional highway safety thinking and programs. It leads typically to such unscientific and illogical statements as, "If it's the driver, what's the vehicle got to do with it?" This is the equivalent of arguing that just because a postal employee can be expected sometimes to drop a parcel, one should therefore pay no attention to whether the package provides the protection necessary to prevent the breakage of its contents. Surely no industrial shipping executive, for example, would be considered either professionally competent or responsible if he only attempted to prevent untoward events and ignored packaging, and salvage-when-damaged activities. Yet this is precisely the equivalent of what has largely served as "highway safety" during six decades of mounting highway losses.

Nor is there any logical reason or possibility for reducing highway losses in damaged people and property by focusing only on single or small numbers of measures, as is still tragically typical of much long-standing panacea-oriented highway safety activity. Highway loss-reduction measures are not mutually exclusive. To the contrary, maximum feasible loss reduction requires a carefully planned *mix* of complementary approaches involving in various degrees 1) measures that reduce the frequency of the undesirable events, 2) measures that ameliorate the potentially harmful interactions of the events themselves, and 3) yet others that reduce the end losses through post-event emergency salvage, repair, and related activities. (My colleagues and I, in late 1966, introduced the terms "pre-crash," "crash," and "post-crash" to have handles to identify these three "phases" of highway-loss contributors, countermeasures, standards resource allocations, and so forth.)[3,4]

The Federal program was conceived and statutorily mandated by the Congress as a program involving a mix of loss-reduction measures not limited only to the traditional measures (which it recognized as grossly insufficient even when applied), but including a wide range of high-priority crash and post-crash phase measures as well. This is reflected in the program centering on the 16 detailed standards and the corresponding grants-in-aid for state and community highway safety programs which, though year-after-year greatly underfunded, has received since its beginning the overwhelming majority of the Federal highway safety dollar and personnel resources.* The breadth of the approach across all three phases is also true of the much more publicized new vehicle and equipment programs, and of the related standards, whose initial digits, as you know, identify the phase of the highway loss problem to which each is addressed.**

Standard No.	
1	**Periodic Motor Vehicle Inspection**
2	**Motor Vehicle Registration**
3	**Motorcycle Safety**
4	**Driver Education**
5	**Driver Licensing**
6	**Codes and Laws**
7	**Traffic Courts**
8	**Alcohol in Relation to Highway Safety**
9	**Identification and Surveillance of Accident Locations**
10	**Traffic Records**
11	**Emergency Medical Services**
12	**Highway Design, Construction and Maintenance**
13	**Traffic Control Devices**
14	**Pedestrian Safety**
15	**Police Traffic Services**
16	**Debris Hazard Control and Cleanup**

Such broad federal activities and many corresponding accomplishments on the part of vehicle manufacturers—for example, the provision in some, but not most, present automobiles of special structure designed to reduce human losses in lateral collisions—are beginning to move the emphasis of the entire field to loss reduction, but this is, as yet, little in evidence in routine "safety" activities and messages, or in media reporting. In illustration, there is as yet scant public notice or understanding of the fact that a death resulting from hitting a roadside light, sign, or other pole is usually evidence of lethally inappropriate environmental management, in the placement of the pole, in the absence of an intervening guard rail, or commonly, in the failure of some responsible official to require the use of a "breakaway" pole that would have yielded gently rather than sentencing another American needlessly to death. Similarly, the public apparently does not yet know either that many present highway deaths could be prevented by further advances in proper crash packaging, or that different vehicle design approaches that are now rapidly coming within the state-of-the-art would greatly reduce the nation's huge bill for damaged parts, by making vehicles far less susceptible to

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** The titles of the standards issued to date under the Highway Safety Act of 1966 (P.L. 89-564) a number of which deal with more than one phase of loss reduction programs, indicate the breadth and depth of the State and Community program.*[5]

*** The new vehicle and equipment programs are under the National Traffic and Motor Vehicle Safety Act of 1966 (P. L. 89-563).*

damage. The public is apparently also not yet aware of the appreciable reductions in otherwise fatal and nonfatal injuries, that research on individual crashes is demonstrating, are already being achieved through the vehicle crash design progress of the past few years.

Many considerations must underlie the choice of the mix of loss-reduction measures, their timing, and emphasis. These include:

1) the relationship between their cost, if implemented, and the payoffs in damage to people and property prevented, and

2) the time needed to achieve payoff. The behavior of societies commonly changes appreciably only over generations, road layouts chiefly only over centuries, and roadsides—with public pressure—somewhat more quickly. The vehicle, by contrast, is by far the most rapidly changing and changeable component in the system. Considering this, and the fact that even the early payoffs in injury prevention through improvements in vehicle crash design (and potentially, highway crash design as well), far exceed those scientifically yet shown to result from either crash prevention or post-crash measures, further vehicle crash design improvements to reduce injury, including now common wholesale disfigurement and death, clearly should have the highest priority in the much broader and also necessary mix of other highway loss reduction measures.

In the context of vehicle crash design measures, a crucial aspect of the problem is receiving insufficient professional attention, at least publicly. The great tolerance, provided maximum values are not exceeded, of the properly packaged human body to forces of the transience and directions typical of many vehicular crashes has been reasonably well known in physics terms for years.[6] The maximum forces that a decelerating body (whether car, human, or other) must experience in coming violently to a stop in a given distance have been known in elementary physics since Isaac Newton three hundred years ago and are elementary to this audience. It thus becomes entirely feasible, just as I believe it is necessary to the public interest, for professionals in this field to establish a standard method for rating any given vehicle in terms both of the maximum forward speed of crash (under standardized conditions) in which it will not subject its unrestrained "standard occupants" to injurious forces (ie, to any forces at or in excess of injury thresholds), and of the percentage of the theoretically possible protection it affords at that and other speeds. I believe that if such information were available publicly we would find that present crash performance falls far below that which could be achieved with vehicles of present dimensions, and therefore that assertions that additional, appreciable progress in reducing human losses through further advances in vehicle crash design is rapidly reaching a point of diminishing returns are not now professionally and scientifically supportable.

Another loss-reduction problem that should concern engineering professionals in this field is the glaring discrepancy in acceptable engineering practice between closely related fields. If an aeronautical engineer were to design a landing gear—even for a plane of automobile size—that in absorbing the expected hard bumps of many landings produced any amount of structural, not to speak of passenger, damage, he would be considered incompetent, and his product, if built, probably unsalable. Yet, although there is no engineering necessity to do any structural damage in absorbing energy in at least fore-and-aft impacts at the low speeds generating a huge proportion of the nation's dollar losses in highway crashes, auto design continues to absorb the energy of even 5 to 20 mph crashes by damaging structure, an archaic engineering solution, and one, I believe, that will soon be publicly unacceptable in this country.

The owner of a late model car spends from 60% to 80% of his premium dollars on vehicle, rather than injury insurance.[7] When analyses are made of the size of the claims for vehicle damage it is found that most are of relatively small size, cumulating to the huge national losses now exceeding some $12 billion per year in physical damage alone.[8]

Even when weighted for claim size, the small claims contribute overwhelmingly to the overall dollar losses.

As you may know, these data are from much more extensive information given in Congressional testimony, accompanied by information showing that low speed (5 and 10 mph) barrier impacts of standard sedans produced dollar damage far exceeding the size of most of the property damage claims.* This problem of largely eliminating fore-and-aft automobile, low speed crash damage from the United States is largely soluble using present engineering knowhow, copying, for example, from the far more advanced engineering of the aircraft strut manufacturers. These, then, are some of the considerations the public, and especially the members of this professional society should consider in approaching the reduction of the appalling losses of one of our nation's most urgent and costly ecologic problems.

** See appendix for the parts, labor, and dollar costs of 5 and 10 mph barrier crashes of four kinds of standard 1969 four-door sedans.*[9]

APPENDIX

LOW-SPEED BARRIER CRASH TESTS

5 mph Front	*Parts*	*Paint & Sublet*	*Labor (Hours)*
A. 1969 Chevrolet Impala 4-door			
Replace front bumper	$ 65.50		2.3
Repair front bumper back bars			0.5
Replace grille lower	8.50		
Replace grille bumper lower guards L & R	11.00		
Replace grille center	14.95		
Repair grille vertical support			0.3
Repair radiator core support & baffles			1.0
Repair hood panel			3.5
Repair fender R/F			1.0
Refinish as necessary		$ 6.00	3.0
			* 11.6 hrs.
Subtotals	$ 99.95	$ 6.00	$81.20
TOTAL $187.15			
B. 1969 Ford Galaxie 500 4-door			
Replace front bumper	$ 52.30		0.7
Repair front bumper back bars			0.5
Replace fender extension R/F	8.70		0.6
Replace fender extension L/F	8.70		0.6
Repair hood panel			1.0
Repair fender R/F			4.0
Repair fender L/F			0.8
Replace fender lower rear moulding R/F	3.10		0.3
Replace door moulding lower L/F	3.90		0.3
Refinish as necessary		$ 8.00	4.0
			* 12.8 hrs.
Subtotals	$ 76.70	$ 8.00	$89.60
TOTAL $174.30			
C. 1969 Plymouth Fury I 4-door			
Replace front bumper	$ 53.55		0.8
Repair bumper back bars			0.5
Repair front bumper lower panel			1.0
Replace grille center	19.50		0.8
Repair radiator core		$10.00	
Repair radiator core support			1.5
Replace hood moulding	1.70		0.2
Repair hood panel			1.0
Refinish as necessary		2.00	1.0
			* 6.8 hrs.
Subtotals	$ 74.75	$12.00	$47.60
TOTAL $134.35			
D. 1969 Ambassador SST 4-door			
Replace front bumper	$ 54.35		1.0
Repair front bumper back bars			0.5
Repair front bumper lower panel			0.5
Repair grille center	36.50		0.5
Repair radiator core support			2.0
Replace fender extension L/F & R/F	9.30		1.0
Repair fender R/F			3.0
Repair fender L/F			2.5
Repair hood panel			5.0
Repair cowl L/F			1.5
Repair door L/F			0.5
Repair door R/F			1.0
Refinish as necessary		$16.00	8.0
			*27.0 hrs.
Subtotals	$100.15	$16.00	$189.00
TOTAL $305.15			

5 mph Rear	*Parts*	*Paint & Sublet*	*Labor (Hours)*
A. 1969 Chevrolet Impala 4-door			
Replace rear bumper face bar L & R	$ 33.90		1.7
Repair rear bumper back bars			1.0
Repair deck lid			1.0
Repair quarter panel L			2.5
Repair quarter panel R			10.0
Refinish as necessary		$10.00	5.5
			* 21.7 hrs.
Subtotals	$ 33.90	$10.00	$151.90
TOTAL $195.80			
B. 1969 Ford Galaxie 500 4-door			
Replace rear bumper face bar	$ 50.25		1.0
Repair rear bumper back bars L & R			1.0
Repair lower body panel & floor			2.0
Replace quarter panel extension & moulding L	18.35		0.8
Repair quarter panel center L			3.0
Repair frame rail L			3.0
Refinish as necessary		5.00	3.5
			* 14.3 hrs.
Subtotals	$ 68.60	$ 5.00	$100.10
TOTAL $173.70			
C. 1969 Plymouth Fury I 4-door			
Replace rear bumper face bar	$ 52.80		0.8
Repair rear bumper back bars			1.0
Repair lower body panel			2.0
Repair quarter panel L			3.5
Refinish as necessary		$ 6.00	3.5
			* 10.8 hrs.
Subtotals	$ 52.80	$ 6.00	$82.60
TOTAL $134.40			
D. 1969 Ambassador SST 4-door			
Replace rear bumper face bar	$ 54.35		1.1
Replace rear bumper back bars vertical	1.60		
Repair rear bumper back bars L & R			1.0
Repair rear lower body panel			1.0
Repair deck lid			2.5
Replace quarter panel extension L & R	22.00		1.2
Repair quarter panel outer L/R			11.0
Replace quarter panel outer moulding U&L, L/R	4.00		0.4
Replace & finish quarter panel outer moulding, L/R	7.45		
Repair quarter panel outer R/R			8.0
Replace quarter panel name plates L & R	3.70		0.4
Replace quarter panel outer moulding U&L, R/R	4.00		0.4
Replace & finish quarter panel outer moulding, R	7.45		
Refinish as necessary		$10.00	7.0
			* 34.0 hrs.
Subtotals	$104.55	$10.00	$238.00
TOTAL $352.55			

* Labor charged at $7/hour

10 mph Front	*Parts*	*Paint & Sublet*	*Labor (Hours)*
A. 1969 Chevrolet Impala 4-door			
Replace front bumper face bar	$65.50		2.3
Replace front bumper face bar guards L & R	11.00		
Replace front bumper lower valence	9.75		0.6
Replace front bumper back bars—inner	11.00		
Replace front bumper back bars—outer	9.00		
Replace grille lower	8.50		0.2
Replace grille upper and emblems	18.10		0.5
Replace grille vertical support	2.25		
Replace grille upper tie bar (fender)	5.15		0.3
Replace grille support outer L & R	3.50		
Replace radiator core support	26.75		1.5
Repair radiator core		$12.00	
Replace radiator fan shroud	8.25		
Replace fender L/F	64.50		1.5
Replace fender moulding—upper L/F & R/F	21.50		1.2
Replace fender moulding wheelhouse, L/F & R/F	15.90		0.4
Replace fender R/F	64.50		1.5
Replace fender inner skirt, L & R, straighten			3.0
Replace hood panel	71.25		0.9
Replace windshield lower reveal moulding	15.80		0.8
Replace windshield wiper blade L	3.40		
Repair cowl panel R/F straighten			1.5
Repair cowl panel L/F straighten			0.5
Repair door assy. L/F, straighten and align			1.0
Repair door assy. R/F, straighten and align			1.5
Replace rocker panel moulding R	9.25		0.4
Replace door assy. L/R, straighten and align			0.5
Refinish as necessary		15.05	7.6
			* 27.7 hrs.
Subtotals	$444.85	$27.05	$193.90
TOTAL $665.80			

B. 1969 Ford Galaxie 500 4-door			
Replace front bumper face bar	$ 52.30		1.4
Replace front bumper face bar panel	4.00		
Replace front bumper back bars—outer L & R	1.80		
Replace front bumper back bars—inner L & R	12.90		
Replace front bumper gravel deflector	10.55		0.6
Replace grille assembly	31.70		0.5
Replace grille assembly brackets L & R	2.60		0.4
Replace H/L door L	8.10		0.3
Replace radiator core support, straighten and align			1.5
Replace fender L/F	59.90		2.0
Replace fender extension L/F	8.70		
Replace lower moulding rear L	3.10		0.3
Repair fender inner skirt L/F, straighten			0.5
Replace fender R/F	59.90		2.0
Replace fender extension R/F	8.70		
Repair fender inner skirt R/F, straighten			1.0
Repair hood panel, straighten and align			2.5
Replace hood panel, lower latch and supports	3.75		0.2
Replace fan shroud	11.65		0.3
Repair door assy. R/F, straighten and align			1.0
Repair door assy. L/F, straighten and align			1.0
Replace transmission rear extension housing	32.00		1.2
Eleven quarts transmission fluid	6.05		
Refinish as necessary		$9.80	5.8
			* 22.5 hrs.
Subtotals	$317.70	$ 9.80	$157.50
TOTAL $485.00			

C. 1969 Plymouth Fury I 4-door			
Replace front bumper face bar	$ 53.55		1.0
Replace front bumper back bar—outer L & R	8.20		
Replace front bumper back bar—inner L & R	7.40		
Replace front bumper gravel deflector	13.75		0.7
Replace grille assy.	19.50		0.8
Replace grille vertical support—outer L & R	3.90		
Replace grille vertical support—center and lock support	4.85		0.3
Repair radiator core support			2.0
Replace radiator core assy.	88.85		1.0
Replace radiator fan blade	4.50		0.4
Replace H/L doors L & R	13.50		0.4
Replace fender L/F	60.00		2.1
Repair fender inner skirt L/F			
Repair fender front extension L/F	8.60		
Replace fender R/F and Brace	61.50		2.1
Replace fender extension R/F	8.60		
Repair fender inner skirt, straighten			1.0
Replace hood panel and align hinges	75.80		1.9
Replace hood latch—upper	3.25		
Repair cowl L/F			1.0
Repair cowl R/F			1.0
Replace lower windshield moulding	12.50		0.5
Replace windshield wiper blade R	3.50		
Repair door assy. L/F, align			0.5
Repair door assy. R/F, align			0.5
Refinish as necessary		$16.00	8.0
			* 25.2 hrs.
Subtotals	$451.75	$16.00	$176.40
TOTAL $644.15			

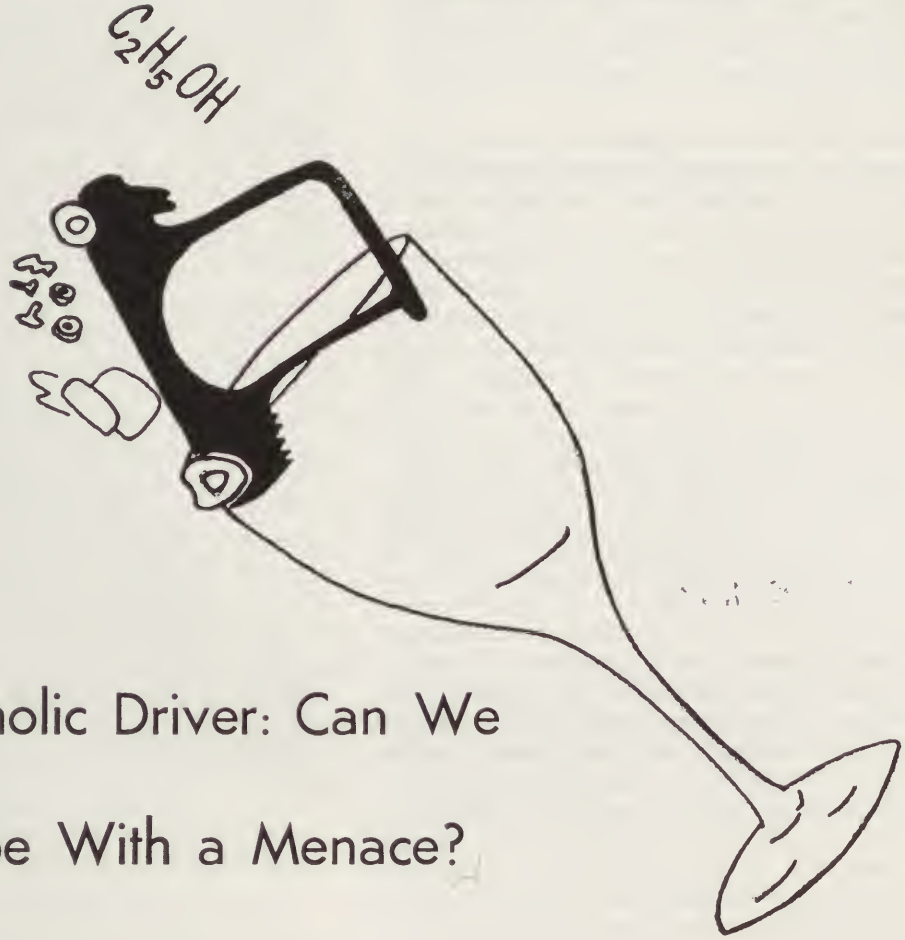
D. 1969 Ambassador SST 4-door			
Replace front bumper face bar	$54.30		1.0
Replace front bumper back bars—outer L & R	4.60		
Replace front bumper back bars—inner L & R	7.00		
Replace front bumper gravel deflector	15.75		0.5
Replace grille assembly	36.50		0.5
Replace grille assembly support brackets	4.00		
Replace headlamp doors L & R	19.10		
Replace headlamp outer assembly L & R	21.70		0.5
Repair headlamp mounting plates L & R			1.0
Repair radiator core support and baffles			2.0
Replace radiator core assembly	78.65		0.8
Replace radiator fan blade assembly, 7 blades	18.50		0.5
Replace fender L/F	62.65		2.5
Replace fender extension L/F	4.65		
Replace fender lower moulding L/F	1.30		
Replace fender wheel open moulding L/F	4.05		
Replace fender decal	18.95		1.1
Replace fender R/F	62.65		2.5
Replace fender extension R/F	4.65		
Replace fender wheel open moulding R/F	4.05		
Replace fender decal	18.95		1.1
Repair fender inner skirts and baffles L/F			2.0
Repair fender inner skirts and baffles R/F			2.0
Replace hood panel and align hinges	78.30		1.3
Replace cowl upper top panel	11.95		0.5
Repair cowl assembly and door assembly L/F			1.0
Repair door assembly R/F, straighten and align			2.5
Replace motor mounts L & R	9.10		0.8
Replace motor mounts rear	5.60		0.4
Replace fan shroud	7.50		
Replace drive shaft		$10.00	
Refinish as necessary		16.65	8.9
			* 33.4 hrs.
Subtotals	$554.45	$26.65	$233.80
TOTAL $814.90			

References will be supplied upon request.

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The Alcoholic Driver: Can We Cope With a Menace?

An excellent brochure prepared by the Office of the Highway Safety Coordinator of Maryland [1] begins with the disturbing question, "WHY Doesn't Somebody Do Something About Traffic Safety?" It goes on to say that there are more than 200 motor vehicle accidents every day in Maryland and that as a result, two people are killed and more than 100 are injured or maimed every day in the year. What must be added is the startling fact that the excessive use of alcohol contributes to half of these accidents and that "alcoholics and other problem drinkers, who constitute but a small minority of the general population, account for a very large part of the overall problem." [2]

Fortunately, Maryland is in an enviable position to launch a comprehensive attack on the drinking driver problem. Maryland is the only state, thus far, to have passed an expressed consent law, as opposed to implied consent. Also, the Comprehensive Intoxication and Alcoholism Control Act charges the Division of Alcoholism Control in collaboration with the courts, police, and the Department of Motor Vehicles, with responsibility for proposing appropriate programs of alcoholism education and treatment for individuals convicted of "driving under the influence". The Division has therefore created a Task Force on Traffic Safety to take significant new steps to implement, with greater effectiveness, the national standard on Alcohol in Relation to Highway Safety.

Because Maryland is regarded in national circles as having one of the best alcoholism treatment programs in the country, it was selected as one of three states to participate in a working conference in November 1969 in Ann Arbor, Michigan, on "Community Response to Alcoholism and Highway Crashes". A significant theme at the conference was the use of "constructive coercion" in uncovering the basic motivation in all suffering alcoholics to secure help for their addictive abuse of alcohol. That layers of resistance and rationalization, laid down in a society which itself resists the understanding of alcoholism as an illness, can be stripped away by the work of alcoholism counselors and therapists, will be seen in the following report prepared by two of the authors (A.M.S. and N.W.):

> "A number of patients presenting themselves at the Baltimore City Department of Health's Alcoholism Center come with a well defined goal in mind. These patients seem to be motivated to stop drinking, not for what alcohol is doing to them physically and psychologically but in order to hold their job, regain their driver's license, etc. They usually appear to be under great pressure and are quite intolerant to frustration or any delay in obtaining their objective. Basically they have not accepted the fact that they are alcoholics in need of treatment and, on the surface, appear to accept what the clinic has to offer in treatment—sometimes going so far as to take Antabuse. The therapist is frequently the frustrating agent in their eyes, and the one who callously is causing the delay in reaching their goal. With the patient who feels this way, considerable energy will be generated in finding ways and means of manipulating the situation.
>
> "The following two cases are men who were referred to the Center for treatment as part of the process of having their driver's licenses reinstated.
>
> "The first case, Mr. L., was seen at the clinic for the first time on March 22, 1968. He came to us for help in dealing with the many pressures and problems that were converging on him from all sides. He had lost his job with the Pennsylvania Railroad Company after 28 years, his wife was planning to leave their home and move into an apartment on her own, and he had lost his driver's license for driving while intoxicated.
>
> "Mr. L. is a handsome man with a smooth manner. Undoubtedly he had held off disaster for years with his charming and pleasing ways, but now he was full of self-pity and badly frightened. He was not ready at first to accept much responsibility for his actions that had brought on the current disasters and put the blame on others. He did not see himself as an alcoholic, though he was very willing to give lip service to the idea.
>
> "Mr. L. had three goals in mind, in the following order of importance: (1) to be given another chance by his wife; (2) to have his driver's license restored; and (3) to find a job. Goals one and three were quickly attained, but getting a driver's license was quite another matter. His frustrations mounted and he began to lose his smooth manner. He had trouble accepting the fact that the clinic could do no more than send his attendance record to the Department of Motor Vehicles and give him prescriptions for Antabuse. Although he seemed to be cooperating in his treatment program, this was not enough for Mr. L., and he sulked and became impatient. After taking Antabuse for a short period of time, he felt he could do without it. When, upon request, another report was sent to the Department of Motor Vehicles indicating his withdrawal from Antabuse, Mr. L. promptly reacted by writing threatening letters to the Center and to the Department of Motor Vehicles and doing much "VIP" name-dropping. However, he quickly resumed taking Antabuse and continued to attend group meetings at the Center.
>
> "Following this flare-up, Mr. L. settled down and his participation in group sessions changed from a passive, smug one to an active, mature one. He stopped trying to bully his way to his goal and came to grips with his own immaturity. He even said in a group session regarding someone else's problem, 'Don't expect the clinic to lie for you—they won't'.
>
> "In June 1969, Mr. L.'s driver's license was reinstated. Mr. L. was pleased but made no big issue of it and continued taking Antabuse and attending his meetings. There has been a marked change in his manner of handling himself, and his group feels that his battle to get his driver's license was significant, since this was the first time that what he wanted was not handed to him on a silver platter.

Immature Patient Faces Reality

"The second case, Mr. K., concerns a 36-year-old man who was first seen at the clinic in 1965. He had a long history of trouble with the law since the age of 17 and numerous state hospital admissions due to his alcoholism. He had a fifth grade education and his work record was spotty. In 1962 he married a patient he had met at a state hospital and had two children. Mr. K. is a well-built virile-looking man with a very appealing personality. He enjoys playing the clown and also overtly admires women. In the beginning, his approach to the clinic was casual and his attitude was, 'I'll try to be a good boy'. He did not seriously accept the fact that he could not drink and wasted much time trying to prove to himself that he could. He obviously needed to drink to prove his masculinity to himself and to his crowd. It was difficult for Mr. K. to accept the fact that he had many other likeable traits besides the "clown" and "lothario".

"Mr. K.'s course in the clinic remained very erratic until July 1967, when he agreed to try Antabuse. This decision followed a group session when he had complained bitterly that the clinic was not helping him get his driver's license. At this point, the group confronted him: 'If you were in their place, would you recommend that you be reinstated?' Mr. K. was forced to admit that the clinic had no choice in the matter if he continued to drink. So, Mr. K. started on Antabuse. Now, instead of pushing people around, he felt he was being pushed and maneuvered into sobriety and this he resented, so on two different occasions he drank on top of taking the Antabuse. Again his behavior got him nowhere, so slowly but surely he began to look at and face up to the reality that was confronting him on all sides. He stopped drinking.

"Mr. K., to the best of our knowledge, had his last drink in November 1968 when he and one of the clinic patients went drinking and dancing. The following day a most contrite Mr. K. called and was told he could return to Antabuse in two days, which he did. In March 1969, his driver's license was reinstated.

"Since Mr. K. finally achieved his goal he has continued to attend group therapy sessions, perhaps more frequently than previously. He has developed some leadership qualities that must give him great satisfaction. We no longer have to contend with a stubborn "actor", and his manner is mature and level-headed. His marriage appears to be running smoothly and he is holding down a good job.

"These two cases illustrate the effectiveness of a firm, steady stance in helping the alcoholic face the reality of the given situation. To realize that no one can or will run his life for him is a big step forward. If he wants to achieve a certain goal, we will support him in his efforts, but the goal will remain his and the rules will be guidelines. We cannot cover up for him and, in the long run, his own recommendations for himself will be the ones that count."

Treatment facilities and services for alcoholics will represent an integral part of any practical effort to reduce the toll of traffic accidents. The practicing physician to whom the patient, who often conceals or denies his alcoholism, turns for help with drinking problems must learn to confront the patient with the realistic consequences of his behavior disorder without, in any sense, being punitive. Alcoholics *can* be helped to recover and the effect on our highway statistics should be astonishing to the many skeptics. Certainly the rest of the nation is looking to Maryland to continue its leadership in what has been called the nation's number one public health problem.

REFERENCES

1. 16 Standards for Maryland Highway Safety Program, The Office of the Highway Safety Coordinator, Baltimore, February 1969.
2. Alcohol and Highway Safety, A Report to the Congress from the Secretary of Transportation, U.S. Department of Transportation, August 1968.

Sex

The role of the physician changes from time to time and is dependent upon many variables. We are in a most unique position, for although our job is to relieve suffering and stave off death, we can at best only temporize, since all of our patients are going to die someday of something. We are one of the few callings who are in business to do ourselves out of business.

As the preventers of disease, what then is really our responsibility and, what are we doing to prevent accidents and death on the highway? It would appear that our responsibility is certainly great as we see the horrible results of traffic accidents and know that practically all of these accidents can be prevented.

What, then, can you and I do about applying good scientific methods to accident prevention? Some of the suggestions we can follow to help prevent accidents ourselves include always, and in all ways, driving defensively, maintaining our cars in the best possible shape, and insisting on owning all optional safety devices, including the proper tires at the proper inflation for your car. Limit your driving when tired, emotionally upset, or under the influence of alcohol. Adjust your driving and speed to current conditions of the highway, weather, and traffic. Don't rush, keep your temper, and personally, in your own community, support better law enforcement, highway improvement, driver education in the schools, and improved driver licensing. Be firm about any patient's medical disability which should keep him or her from driving a car.

Now, how can we help prevent injury in the case of the "second collision", that is, the passenger colliding with the inside of the car? First, and foremost, *use* the seat belt and shoulder harness. Insist upon buying and driving that car with the greatest number of safety features such as padded dash, collapsible steering wheel, and head supports, and such occurrences can be prevented. Unfortunately, we do not seem to be doing much about seeing to it that they do not take place.

Modern Medicine published a series of articles in the spring of 1967 about "The Physicians' Role in Highway Safety", and the Travelers Insurance companies sent out a booklet called "Was It Sudden?" They both point out ways we can help to reduce the accident rate, with its concomitant pain and anguish. They suggest that simply to blame the car, the driver, alcohol, poor roads, conditions, or any one single cause is far from a scientific approach to the problem. The causes of accidents are many, and work in a "system" or chain reaction to bring a tragic or happy ending to any driving experience. You have a car in more or less good condition, and then you yourself—tired, awake, worried or relaxed, on a road that is well-lighted or dark, and wet or dry. Then add or take away any one of another thousand or more factors, and you may have some leads as to the causes of accidents. Remember also that the higher the speed, the greater the severity of the accident.

There are misconceptions in the minds of some people which we must help put aright. For example, some have suggested that a seat belt would prove fatal in case of fire or submergence. The facts are that the chances of survival are greatly increased with the use of the seat belt, since the passenger has been protected from the "second collision", and is, therefore, much more likely to be conscious and able to escape. In every discussion of safety, there is usually one person who knows of someone who was thrown from a car and suffered only minimal injuries. For every one of those cases, we can show you ten whose lives were saved by being belted in. And so, on and on with the feeble excuses that keep you from facing the obvious fact that you and your family can be killed or maimed, in your own car, today. If you carry insurance on your car for fear it might be damaged, take out some safety and accident insurance for yourself, for fear you and yours might be damaged. There is a shortage of physicians. Please don't be afraid to be afraid.

Oh, yes, if you have wondered why this was entitled "Sex", be honest, now. Would you have read it at all if it had been called "Automotive Safety?"

Our greatest accomplishments as physicians have really been in the field of preventive medicine. It seems odd, then, that we the preventers, the healers, would do so little about a preventable phenomenon—traffic accidents —that kills about 60,000 men, women, and children each year, and injures about 4-1/2 million.

WILLIAM K. KELLER, MD Chairman

Kentucky Medical Association Committee on Highway Safety

Reprinted courtesy of the Journal of the Kentucky Medical Association, *September 26, 1967.*

your medical faculty at work

by John Sargeant
Executive Director

The Executive Committee met on Thursday, March 12, 1970, and took the following actions:

1. Declined to concur in the request of the MEDIC Subcommittee to request all chiefs of staff at all Maryland general hospitals to permit substitution of attendance at MEDIC programs for required attendance at staff meetings;
2. Declined to circulate a letter urging members to purchase U.S. Savings Bonds;
3. Authorized the attendance of the **Executive Director** and **Arthur G. Siwinski, MD,** at a regional conference on Quackery scheduled for Boston on Friday, May 1;
4. Declined to endorse a proposed educational symposium/tour to be sponsored by Squibb and Company;
5. Directed that a list of hospitals, scheduled for JCAH resurveys in 1970, should be included in the next Executive Director's Newsletter. Physicians are requested to advise the Faculty staff of any problems that should be specifically investigated;
6. Adopted a position that the concept of special diets for welfare recipients are warranted when the medical condition of the patient requires such treatment;
7. Agreed to meet jointly with the Maryland State Dental Association Executive Committee at the Statler-Hilton Hotel, Annapolis, on Tuesday, May 19, at 6:00 PM to discuss mutual problems;
8. Authorized the President to prepare a list of nominees for consideration by the Governor for possible appointment to the Board of Nursing Home Administrators Examiners;
9. Authorized the sum of $450 as a contribution to the University of Maryland School of Medicine Student AMA Chapter to assist in its regular activities, as well as a special regional meeting;
10. Heard further information with respect to the 1970 budget and formulated recommendations for presentation to the Council;
11. Received for information a copy of a letter to the President of the United States from Ross Z. Pierpont, MD, regarding education of physicians.

The Council met on Thursday, March 19, 1970, and took the following actions:

1. Renewed, on recommendation of the Executive Committee, the contract of the Executive Director for a three-year term on the same conditions and terms as previous years;
2. Approved the revised budget for 1970 operations;
3. Referred two resolutions from Prince George's County to the House of Delegates for consideration and any action it may wish to take;
4. Affirmed action of the Bylaws Committee in connection with a proposed Bylaw amendment from the Montgomery County Medical Society;
5. Heard a report from the Legislative Committee chairman on current activity in the State Legislature;
6. Adopted a resolution on Transportation of Emotionally Ill Patients which appears at the end of this report;
7. Adopted a position of support for repeal of all abortion laws in Maryland;
8. Authorized employment of Public Relations Consultants for the annual session;

(Continued next page)

9. Determined that no annual or semiannual session should be held outside of a 200 to 300 mile radius of the Baltimore city area, but that nothing precludes any postconvention session being held outside of this radius;
10. Authorized the Executive Committee to meet with Hospital Council representatives to discuss current refusal of payments for medicare patients in hospitals throughout the State.

Transportation of Emotionally Ill Patients

WHEREAS, Humane and therapeutic considerations clearly dictate that all psychiatric patients, under all circumstances, be treated with respect and dignity, as well as sympathy and compassion for all his needs and feelings, and

WHEREAS, Initial contacts and subsequent handling of such psychiatric patients immediately following departure from familiar and homelike surroundings have a great bearing on the long-term welfare of the patient, and

WHEREAS, Methods and procedures followed in transporting patients to psychiatric care facilities should be selected with due recognition of the psychological effect on such patients at a time of crisis in his life; therefore be it

Resolved, That the Medical and Chirurgical Faculty of Maryland urges the Department of Health and Mental Hygiene to assume leadership in initiating collaboration with local health authorities for the purpose of studying the problems presently encountered in the transportation of emotionally disturbed patients and devising realistic plans for the resolution of said problems.

The Council met on Wednesday, April 1, and Friday, April 3, 1970, and took the following actions:

1. Adopted various minutes of previous sessions;
2. Expressed appreciation to the outgoing Council members and to the Council chairman for service during the past year;
3. Elected **Manning W. Alden, MD,** Annapolis, as Council Chairman;
4. Elected **John M. Dennis, MD,** Baltimore, as Council Vice-Chairman;
5. Elected **Arthur G. Siwinski, MD,** Baltimore, to serve the balance of an unexpired term of **Harry M. Robinson, Jr., MD,** Baltimore, who resigned from the Council. The term expires with the annual meeting, 1971.

The House of Delegates met on April 1, 1970, and took the following actions:

1. Adopted minutes of previous House sessions;
2. Heard brief comments from presidents of the West Virginia and Pennsylvania Medical Societies;
3. Observed a moment's silence in memory of deceased members;
4. Adopted a resolution honoring **Robert W. Johnson, MD,** 1891-1969;
5. Presented an Honorary Membership certificate to **W. B. Kouwenhoven, Dr.Ingr., MD (Hon);**
6. Awarded Fifty-Year pins to the following:

Baltimore City: **Leslie N. Gay, MD**
Louis F. Krumrein, MD
F. Fred Ruzicka, MD
Austin Wood, MD
Allegany County: **Howard L. Tolson, MD**

The following members could not be present for presentation of their pins:

Baltimore City: **Zachariah R. Morgan, MD**
John G. Murray, MD
Baltimore County: **Lee K. Fargo, MD**
Carroll County: **Charles L. Billingslea, MD**

7. Granted Emeritus Membership to the following:

Baltimore City:	**Melvin H. Crocker, MD**
	Walter E. Fleischer, MD
	Ralph S. Penner, MD
	Alexander J. Schaffer, MD
	Joseph Sindler, MD
	Harry B. Smith, MD
	William S. Stone, MD
Baltimore County:	**William E. Martin, MD**
	William H. F. Warthen, MD
Carroll County:	**Charles L. Billingslea, MD**
Montgomery County:	**Paul N. Fleming, MD**
	Paul V. Starr, MD

8. Heard comments from the President regarding the Medicare and Medicaid programs; the importance of Peer Review activities; and the professional liability insurance program;
9. Deferred action until the Friday session on two resolutions referred to the House by the Council through Prince George's County Medical Society;
10. Heard a brief report from **George G. Finney, Jr., MD,** Baltimore, as chairman of the Maryland Medical Political Action Committee;
11. Received the 1970 budget from the Treasurer;
12. Adopted the following two motions regarding the MEDIC program:
    (a) That the MEDIC Network be continued and that such funds to the extent of $16,000 be appropriated to finance the operation of the system for a one-year period, in order to produce stability and enable proper planning of programs of desired quality
    (b) That a formal evaluation of the MEDIC program be made available when this item is up for consideration again;
13. Adopted various Bylaw amendments;
14. Adopted the following amendment to the Medicolegal Code of Cooperation:
    "Upon engaging a physician for consultation, evaluation and/or testimony, the attorney should make it clear whether the patient or the attorney will be responsible for payment of the fee."
15. Received the Nominating Committee Report and received no nominations from the floor;
16. Heard a verbal report from the Legislative Committee Chairman on activities during the recent General Assembly session;
17. Adjourned until Friday. (A report on the April 3 meeting will appear in the June *Journal.*)

MEDICAL NEWS

The newly elected executive vice-president of the Good Samaritan Hospital, Inc. is **John C. Harvey, MD,** of Baltimore. Dr. Harvey is professor of medicine at The Johns Hopkins School of Medicine.

* * *

A. Edward Maumenee, MD, professor of ophthalmology and director of the department of ophthalmology at The Johns Hopkins School of Medicine, has been elected president of the American Academy of Ophthalmology and Otolarygnology.

* * *

Liaison between the Student American Medical Association and the American Medical Association staff will be the responsibility of the editor of American Medical News, Marvin L. Rowlands.

The appointment was made by Ernest B. Howard, MD, executive vice-president of the AMA.

Rowlands' assignment will supplement the work of the liaison committee of the AMA Board of Trustees. Irvin E. Hendryson, MD, Albuquerque, N.M., who is vice chairman of the AMA Board, serves as chairman of its SAMA liaison committee.

"I have asked that greater emphasis be placed on liaison between SAMA and the AMA staff, Dr. Howard said. "Marvin Rowlands has been directed to coordinate efforts of the AMA staff to provide every possible assistance which SAMA members and staff request."

Dr. Howard emphasized that the AMA staff recognizes the autonomy of SAMA, but said that the AMA can offer many supporting services to assist the medical students' organization.

The AMA headquarters building is in downtown Chicago and the SAMA executive offices are in Flossmoor, a Chicago suburb.

Rowlands has been a member of the AMA staff since 1958, and editor of *American Medical News* since 1965. Previously, he served as managing editor and an associate editor of the newspaper.

* * *

Thomas B. Turner, MD, dean emeritus of The Johns Hopkins University School of Medicine, has received the William Freeman Snow award for distinguished service to humanity. It is the highest award presented by the American Social Health Association.

* * *

Jonathan E. Rhoads, MD, a 1932 graduate of The Johns Hopkins University School of Medicine, has been named president of the American Cancer Society.

Dr. Rhoads is director of the University of Pennsylvania School of Medicine's Harrison Department of Surgical Research.

* * *

Each morning, five days a week, more than 15,000 people pour into the complex of buildings which make up the Social Security Administration's national headquarters in Woodlawn. For most of them, this is the start of another sedentary day.

More than a year ago, physicians at Social Security and at the Baltimore Public Health Service Hospital decided to find out just what the state of cardiovascular health was at the agency. More specifically, they wanted to know what effects sedentary employment has on the heart.

In an initial IBM card survey of 5,000 male employees, 20% indicated they had either a history of cardiovascular disease, or some symptom or finding suggesting such a disease. The preliminary study convinced Drs. Edward Hinman and Richard Warbasse of the PHS Hospital that a more extensive survey was called for. A massive heart disease prevention and research study—the largest of its kind ever conducted at a Government facility—was launched. Over the next two years, more than 20,000 current and future SSA employees will undergo a battery of tests and X-rays designed to shed more light on the largest single cause of death in the nation.

A team of physicians from PHS and paramedical personnel from both PHS and SSA will be working under unique conditions —a controlled atmosphere.

"The SSA was selected for the study because it has the characteristics and personnel that can provide the information needed to expand cardiovascular knowledge. In addition to uncovering heart disease in its early stages, we hope to learn more about the effects of sedentary employment on the cardiovascular system," the medical director of SSA stated.

Although the study will concentrate on heart disease, it should provide additional information on various related and unrelated illnesses such as lung cancer, tuberculosis and hypertension.

The initial two-year phase will be the first of several in the continuing study. It is planned that follow-up examinations will be repeated after a five-year interval.

* * *

Stewart Wolf, MD, a 1938 graduate of The Johns Hopkins University School of Medicine, has been named scientific director at the Marine Biomedical Institute in Galveston, Texas.

* * *

A new film, "Next Witness," depicts to physicians what may be expected of them if called upon to be a medical witness in personal injury litigation. The film stresses the importance to both the physician and the attorney of pretrial preparation for the medical witness; the story line shows how the lack of preparation could create awkward and embarrassing situations in court. About 70% of all court actions constitutes personal injury litigation, often requiring a physician's testimony.

"Next Witness" is a 16mm, sound color film. Prints are available on loan from the AMA Film Library, 535 North Dearborn Street, Chicago, Ill. 60610.

* * *

A spokesman for the National Association of Blue Shield Plans (NABSP) expressed disappointment over the data in the Report of the Staff to the Senate Finance Committee on the problems of Medicare and Medicaid.

Speaking for NABSP the coordinating office for 72 U. S. Blue Shield Plans which serve more than 76 million Americans, Ned F. Parish, NABSP Executive Vice-President, said in Chicago:

"We were called on by government in 1966 to assist in the administration of the Medicare program, which was designed in a manner contrary to the suggestions we had made based on 25 years of experience.

"Now, we are faced with a report which states that Blue Shield Plans paid more to physicians for taking care of Medicare patients than for patients covered by Blue Shield private programs.

"The report takes Blue Shield fee schedules—some developed more than 15 years ago—and compares them to Medicare payments in 1968. Obviously these fee schedules, some of which were designed for partial payment to physicians, do not meet current physician charges.

"Medicare administration calls for payment to the physician on the basis of the usual, prevailing and reasonable charge. In comparing this with Blue Shield programs based on the same payment principle, there was no significant difference in the amounts allowed to physicians."

Parish said he had testified before the House Ways and Means Committee on November 10, 1969, and had submitted a study entitled "Physician Fees: A Comparison of Government and Non-Government Carrier Payments," which was prepared by Edward S. Mills, PhD, and Theodore F. Lake, MBA, of the NABSP staff.

This study showed that "no statistically significant difference existed between the charge levels allowed by Blue Shield carrier Plans for Medicare and for their private enrollment, when the comparable customary, prevailing and reasonable charge method of payment was used."

Parish said findings of this Blue Shield study were distributed to the news media and government agencies, "and we have not received any comments critical of our approach to the data, and our interpretation of it."

The Blue Shield executive reported that Mills and Lake had analyzed Chart 1 of the staff report and had found the following:

- The Senate staff report indicates an average Medicare payment by Alabama Blue Shield for an inguinal hernia is $193 compared to the Blue Shield maximum payment for private business of $75. The $75 figure is from the Alabama Plan's lowest level contract—last revised in 1956—which was never intended as a paid-in-full schedule.

- For a cholecystectomy operation, the Senate staff report lists an Alabama Blue Shield maximum of $100—again from the lowest level fee schedule—compared to the average Medicare payment of $303. NABSP computation of the Alabama data indicates an average Medicare payment of $289 and a private business average payment of $286.

- In Michigan and Minnesota, the average Blue Shield figure for a prostate operation was higher than the average Medicare payment. In Michigan, the Blue Shield allowance was $398 and for Medicare, $389. In Minnesota, the private subscriber fee was $384, but only $348 for the average Medicare patient.

The Colorado Blue Shield Plan has also taken issue with Chart 1 which shows that the average Medicare cataract operation in Colorado costs $348 as compared to "Blue Shield maximum payment" of $250. The Colorado Plan pointed out that the $348 represented a cataract operation in 1968, compared to a Blue Shield schedule of $250 for this operation in 1953.

The Senate staff report resulted in the following sensational headline in the *Rocky Mountain News* on February 8: "One Colorado Doctor Reaps $326,262 From Medicare." The story indicated that another Colorado physician had

earned some $150,000 from Medicare.

John J. Vance, Executive Vice President of Colorado Blue Shield, said the $326,262 payment was actually made to staff physicians at Colorado General Hospital for hundreds of procedures, X-ray, and laboratory charges by many staff physicians in the teaching institution.

As for the $150,000 payment, this was made to the Denver General Hospital, again for services performed by a number of physicians.

Parish concluded: "It is unfortunate that because of the complexity of the subject a report of this sort is open to such misinterpretations. We are giving our full attention to the report and will make additional comments where warranted.

"We are concerned about rising health care costs and are taking measures to contain them. But in the inflationary economy which we have experienced, it is unrealistic to compare physician charges today with fee schedules developed 10 to 15 years ago for programs which were vastly different from Medicare."

* * *

This year will mark the 42nd observance of May as Better Hearing and Speech Month. During the month, members of hearing conservation teams, hearing aid dealers, audiologists, clinicians and physicians are urged to join with workers in speech therapy in activities that will acquaint the public with information about communications disorders and how they can be served.

There are three main objectives of the 1970 Better Hearing and Speech Month. They are: alerting the public to hearing, speech and language disorders; encouraging students to enter careers servicing the communicatively handicapped; and informing hearing and speech impaired persons about places where treatment and rehabilitation are available.

The Hearing and Speech Agency of Metropolitan Baltimore, Inc. is cooperating in all efforts to inform, educate and serve the community and those persons with communications disorders.

As part of this overall effort the Agency advises a hearing test for those persons with doubt about their hearing and urges all parents to have their children checked for hearing ability, if not before, surely when they are preparing the children for school for the first time. The Agency suggests that hearing is happiness—keep it healthy!

* * *

The Maryland Public Health Association is holding its annual meeting on May 21-22, 1970. Public health and mental hygiene representatives from around the state will meet in Baltimore at the Belvedere Hotel to discuss this year's theme: The Challenges of the 70's.

There will be panel discussions on drug abuse, healthful housing for the poor, accidental injury and death, and alcoholism. The meeting will also include section meetings on nursing, laboratory, environmental health, administration, social work, and speech and hearing.

Keynote speaker for the opening session will be the Rev. Frederick J. Hanna, Coordinator for Drug Abuses Program in Baltimore. Neil Solomon, MD, PhD, State Secretary of Health and Mental Hygiene, will be the guest speaker at noon on Thursday, May 21.

* * *

Ruth Finkelstein, MD, family-planning consultant for the Baltimore Maternity Center, has been appointed to the national medical committee of the Planned Parenthood Association.

Dr. Finkelstein has been a member of the medical board of the Planned Parenthood Association of Maryland. She also served as secretary for the AMA of Planned Parenthood Physicians.

A graduate of The Johns Hopkins School of Medicine, Dr. Finkelstein is attending physician in obstetrics and gynecology at Sinai Hospital in Baltimore, where she was honored in 1967 for 25 years of family-planning service.

* * *

Sister Alberta, DC, administrator of the St. Agnes Hospital, has announced the appointment of **Frederick J. Heldrich, Jr., MD,** as chairman of the Department of Pediatrics. His appointment marks the first time that the department has had a full-time chairman.

A graduate of Baltimore City College, and Gettysburg College in Pennsylvania, Dr. Heldrich received his MD degree from the University of Maryland School of Medicine. He served his internship and one year of his residency at University Hospital in Baltimore, and completed his residency at Mercy Hospital in Baltimore, where he served as chief resident in pediatrics.

Dr. Heldrich currently holds appointments as assistant professor of pediatrics at The Johns Hopkins School of Medicine, and as assistant professor of clinical pediatrics at the University of Maryland School of Medicine.

* * *

James Castellano, Jr., MD, of Woodlawn, has been named chairman of the Department of Obstetrics and Gynecology at St. Agnes Hospital.

Dr. Castellano received his BS and MD degrees from the University of Maryland and served both his internship and residency at St. Agnes Hospital.

A member of the Medical and Chirurgical Faculty, Dr. Castellano is also active in the AMA and the American College of Surgeons. He is a Fellow of the American College of Obstetricians and Gynecologists.

* * *

The American College of Gastroenterology, in cooperation with William H. Rorer, Inc., is sponsoring the 1970 Rorer Awards Contest for the best papers in gastroenterology. There will be two classes of awards: for the best unpublished papers in gastroenterology or an allied subject, and for the best paper published in the *American Journal of Gastroenterology* during the 12 months ending June 30, 1970, for which no previous prize has been awarded.

Deadline for entries is July 15, 1970. For further information, write to the Research and Education Committee, American College of Gastroenterology, 299 Broadway, New York, New York 10007.

* * *

A portrait of **Isadore A. Siegel, MD,** to be hung in Franklin Square Hospital, was recently unveiled in a ceremony honoring Dr. Siegel, who served as chairman of the hospital's Department of Obstetrics and Gynecology for 27 years.

Dr. Siegel graduated from The Johns Hopkins School of Medicine, and served his residency at The Johns Hopkins Hospital. He is a member of the Baltimore City Medical Society. He has served as director of obstetrics at Franklin Square Hospital, attending obstetrician at Sinai Hospital, and assistant professor of obstetrics at the University of Maryland School of Medicine.

* * *

George Patrick Bridger, MD, a Baltimore otolaryngologist, was among four resident physicians who presented papers in competition for the Benjamin Shuster Memorial Award at the sixth annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery, Inc. in Hollywood Beach, Florida in April.

The award was established by the Academy in honor of the late Benjamin Shuster, MD, of Philadelphia, and is presented for outstanding research in head and neck plastic surgery by a resident physician.

Dr. Bridger, a resident physician at The Johns Hopkins Hospital, spoke on "Physiology of the Nasal Valve".

* * *

Recently named representatives to the General Body of the Maryland State School Health Council are Robert J. Dawson, MD, of Cumberland, Julius Loebl, MD, of Annapolis, Martha T. Schipper, MD, of Frederick, and W. Lewis Holder, MD, of Rockville.

* * *

A. Earl Walker, MD, professor of neurological surgery at The Johns Hopkins University School of Medicine, recently attended a conference on the Prevention of Trauma and received an honorary FRCS degree from the Edinburgh Royal College of Surgeons in Edinburgh, Scotland.

* * *

The Division of Emergency Health Services of the Health Services and Mental Health Administration, formerly located in Chevy Chase, has moved its offices into the Public Health Service's new Parklawn Building in Rockville.

* * *

The Lower Eastern Shore Area Comprehensive Health Planning Agency has officially opened in Salisbury. It encompasses the Health Planning Council of the Lower Eastern Shore, and serves Dorchester, Somerset, Wicomico, and Worcester counties. Among the incorporating members are Mr. Norman W. Harrington, of Wicomico County, president; Calvin H. Webster, of Dorchester, vice-president; Dennett L. Butler, of Somerset, secretary; William C. Fritz, MD, of Somerset; Richard E. Hughes, MD, of Wicomico; and Frank E. Gantz, MD, of Worcester.

The agency, part of the State Department of Health and Mental Hygiene, is particularly concerned with consumer interest in health fields.

* * *

Harry B. Cummings, recently retired vice-president of Koppers Company, Inc. and general manager of the Metal Products Division, has been named president of the Board of Trustees of **South Baltimore General Hospital.** He succeeds Frederick W. Wagner, Jr.

Other newly-elected officers include Herbert A. Davis and Carlton E. Smith as vice presidents, Herbert R. O'Conor as secretary, and John A. Luetkemeyer, Jr., as assistant treasurer.

* * *

Herbert W. Lapp, MD, a Howard County physician and a member of the Faculty, was recently cited for his part in helping to capture two would-be thieves. He sustained three bullet wounds, smashed his car, landed in the hospital, and had to curtail his medical practice for two weeks as a result.

As he was backing his car out of the driveway one Saturday night in February, he noticed a rental truck parked in front of his neighbor's house across the street. Recalling several neighborhood burglaries in recent years, Dr. Lapp got out of his car, went over to the truck, and made a mental note of the truck's license number, intending to drive away and call the police. As he was getting back into his

car, however, he saw two men come leaping across the porch railing of his neighbor's house. Three shots were fired from the porch and hit Dr. Lapp. After a few seconds, he heard the truck's engine. Although he was still dazed from the bullet wounds in his arm and head, Dr. Lapp started his own car, shot ahead, and slammed into the truck, stalling the engine and causing the two men to flee on foot.

Meanwhile, the Howard County Police Department had received a call from another neighbor about the truck. As the men fled, Sgt. Burke, of the HCPD, and his men arrived at the scene. A chase followed, and one of the men was finally captured.

"I didn't intend to be a hero," said Dr. Lapp. "You don't know what you'll do until you're faced with such a situation."

Sgt. Burke said, "He's quite a fantastic guy. You hear so much about apathy and then this happens."

* * *

The Professional Forum, an interdisciplinary Baltimore-based organization, has announced that it will provide key members as commentators on a filmed public affairs program to be produced by WMAR-TV for telecasting sometime in June, 1970.

The focus of the program will be on the separation of fact from fiction regarding the Medicare program; the erosion of traditional Constitutional processes; the future of the free enterprise system as it relates to medicine; how mounting crime patterns reflect the accelerated activities of the New Left; and how traditional Protestant and Catholic doctrine must meet the rhetoric of Leftist-leaning theology today. Respective speakers will be Newland E. Day, MD, vice president of the Forum; Thomas N. Clifford, attorney and specialist on federal and state constitutions; William E. Gilmore, MD, president and co-founder of the Forum; Jack Edward Rytten, criminologist, executive director of the organization and a co-founder; and the Rev. Robert C. Smoot, Jr., minister of Chapel Hill United Presbyterian Church and co-founder of the Forum.

Now in its fifth year, Forum members are bound together by mutual concern over the free enterprise system and how it functions in relation to government. According to Mr. Rytten, "If we eventually become a prototype for a national multiprofessional group it will be because all professionals finally realize that they share common standards and identical goals."

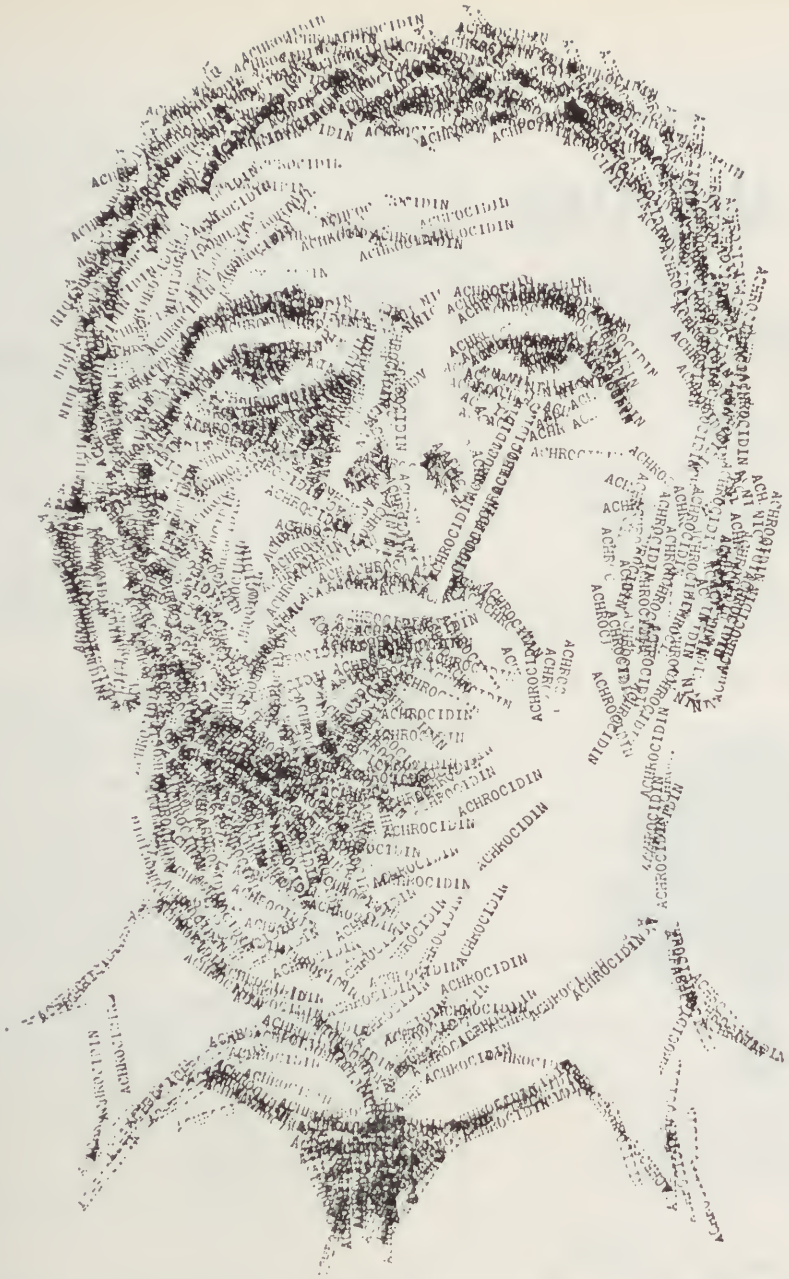
Forum members have been prominently featured on local radio talk shows in the last year, and have been guest speakers before many professional societies throughout the Baltimore area.

Professional people interested in joining the all-male group should contact Dr. Gilmore, Henry L. Wollenweber, MD, chairman of the Committee on Medicine, or Mr. Rytten at Professional Forum headquarters, 816 Munsey Building, Baltimore, Maryland 21202.

* * *



Officers of the Professional Forum (from left to right): Jack E. Rytten, criminologist, executive director (seated); Newland E. Day, MD, vice-president; and Howard E. DeMuth, Jr., attorney, secretary-treasurer, discuss the program entitled "Professional Opinion" to be telecast in June. Key members of the Forum will serve as commentators for the public affairs program.



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SYNOPSIS OF CERVICAL CANCER, Condict Moore, MD; The C .V. Mosby Company, St. Louis, Missouri, 1970.

This summary of clinical cancer information presents 20 years experience in learning, teaching, and practice in the field of oncology. It is very clearly written, concise, yet broad in scope. It includes very recent data, separates pertinent from trivial information, and emphasizes the similarities among the various cancers. In so doing, cancer is placed in better perspective within the field of medicine. This book is certainly worthwhile for every physician who is interested in cancer.

It is a handy review for both the student and the physician in all specialties of medicine and should prepare the reader for future discoveries in the emerging area of cancer prevention, which is destined to become an increasingly important part of medical practice.

SYNOPSIS OF OBSTETRICS, Charles E. McLennan, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This revised edition is designed primarily for the undergraduate medical student who needs an abridgment of the material included in the large standard obstetric textbooks, either for an initial survey of the subject or for a pre-examination review.

The emphasis has been placed on basic principles, and the ever-changing minutiae of drug therapy and mechanical procedures have been omitted. References to current literature are not included, since those reading a synopsis have little time to pursue original sources.

This is a useful reference text and one that should be made readily available to those in need of it.

THE VITREOUS IN CLINICAL OPHTHALMOLOGY, Norman S. Jaffe, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This book was compiled because of the numerous requests directed to the author for information on this subject. Dr. Jaffe is a distinguished lecturer, and teaches a course in this area at the Academy of Ophthalmology and Otolaryngology.

The book is geared to the resident and to the "eye man" in clinical practice, and provides a better framework for understanding the vitreous. A long list of credits to the many contributors who assisted in the preparation of the manuscript is given. A posthumous one goes to J. McGuiness Myers, the famed ophthalmic artist, who did most of the excellent drawings included in the book.

MANIC DEPRESSIVE ILLNESS, George Winokur, MD, Paula J. Clayton, MD, and Theodore Reich, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This soft-cover edition presents data on manic depressive illness collected over the course of many years by the authors. A set of clinical and genetic findings fundamental to the understanding of this illness is also offered.

It describes in some detail the various case histories of the individuals from which data was collected. It is a broad-range study of the entire spectrum of this particular aspect of psychiatric care. Supported in part by various grants from the National Institute of Mental Health, it is worthwhile reading for those involved or interested in this area.

SYMPOSIUM ON OCULAR THERAPY, Volume IV, Irving H. Leopold, MD; The C. V. Mosby Company, St. Louis, Missouri, 1969.

This publication presents the information given at the Drug Symposium of the American Academy of Ophthalmology and Otolaryngology and the Association for Research in Ophthalmology joint meeting held in Chicago in 1968. Each of the presentations is current and differs from those of earlier symposia.

The book is fundamental, practical where possible, and timely. While some areas of the symposium have been changed or modified in accordance with the speakers who participated, these changes only represent new thoughts which have developed since the last presentations were made.

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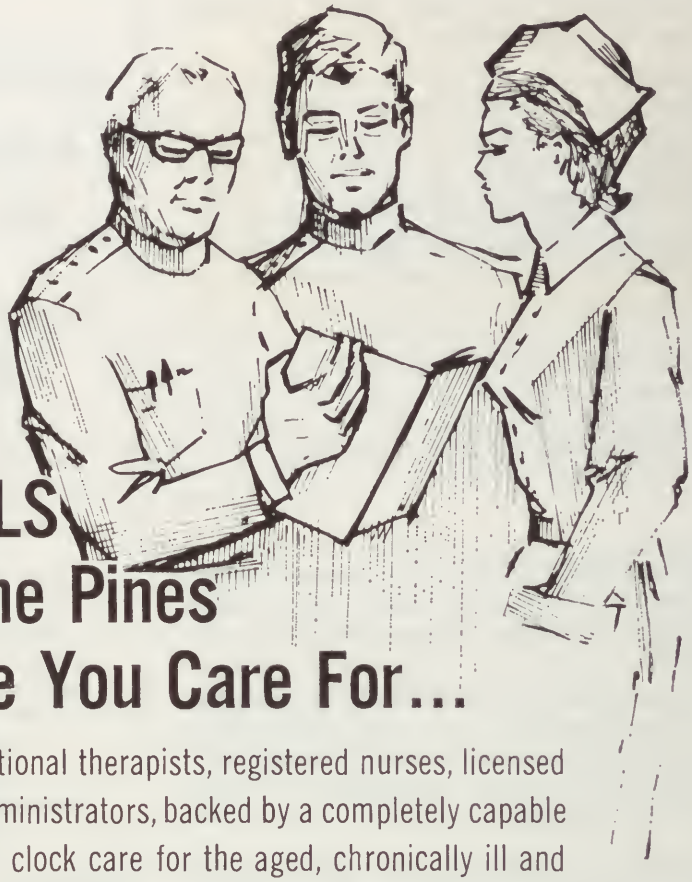
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The Presidents Speak

Mrs. Sadowsky Gives President's Report

Preparing my report as your 20th president prompts much reflection. The Medical and Chirurgical Faculty has chosen for its theme for this year's annual meeting "Medicine Looks to the '70's". It is hoped that as we approach our 21st year in this new decade, the Faculty, as it looks to the '70's, can depend on us as physicians' wives to brighten that outlook.

It has been a great honor for me this past year to have partaken in so many activities as your president. I feel very fortunate to have had the cooperation of dedicated officers, committee chairmen, and component auxiliary leaders. It is with pride that I shall give an account of their accomplishments in the second part of my report.

As your president, I have had the privilege and pleasure of visiting with all but one of the 11 component auxiliaries and installing officers for eight. I am very grateful for having had such an active refresher course in Maryland geography and to have received the hospitality of so many of our members in their own "backyard".

I have been privileged to attend national meetings such as the Annual Convention of the Woman's Auxiliary to the AMA in July in New York city, the Conference of Presidents and Presidents-elect in Chicago in October, the Eastern Regional Workshops in Washington in October, and the National AMPAC Workshop in Washington in February. As your presidential delegate to the national convention, I was proud to accept the membership award presented in recognition for "an outstanding membership program in 1968-1969". At the Conference in Chicago, I was a member of the cast presenting a skit on the use of a package program. At the Eastern Regional Workshop, I substituted for our Health Careers chairman who was unable to attend due to illness.

Since last spring, I have been the recipient of gracious hospitality when I accepted invitations from Pennsylvania, New Jersey, New York, Virginia, West Virginia, and D.C. medical auxiliaries for conferences and annual meetings. It is an inspiring and enlightening experience to witness the work of other state auxiliaries whose goals are so similar to our own.

I attended WA-SAMA's annual luncheon last April; lent a helping hand in the reception following the pre-Commencement exercises of the University of Maryland School of Medicine, where WA-SAMA members who were wives of graduates received certificates; and I attended WA-SAMA's regional convention in Baltimore a few weeks ago. Being with these energetic and youthful Auxiliary members of tomorrow, whom we help by extending counsel and financial assistance, always affords me much inspiration and encouragement.

I extended greetings from our auxiliary to the Future Nurses-Health Careers Clubs of Maryland at their state convention in Westminster last April. I have been asked to address the Spring Delegates Meeting of this same group when it meets at the Faculty building in Baltimore.

I have addressed the 7th District Nurses Association, explaining the purposes of the medical auxiliary, and the Woman's Auxiliary to the Allegany County Medical Society on the role of the auxiliary in community health services.

I have attended "coffees" for members-at-large in Anne Arundel, Howard and Frederick counties, all arranged by a very dedicated chairman whose ef-

forts have greatly increased the number of interested members-at-large.

I attended special fund-raising events in Montgomery County and Baltimore city for the auxiliaries' medical education funds. I accompanied Baltimore County auxilians on a trip to the Center in New Windsor, which has helped the auxiliary carry out its activities for international health.

In May, I represented you at the annual meeting of the Auxiliary to the Maryland Medical Association in Columbia, Maryland. In June, along with your Mental Health co-chairman, Mrs. Gerald Palmer, I attended the Maryland State Mental Health luncheon and meeting and in October, the Maryland State meeting of the American Cancer Society.

I have attended seven meetings of the Faculty's Program and Arrangements Committee, have assisted with arrangements for the Semiannual Meeting in Hershey, Pennsylvania, in September 1969, and organized an innovation in the program—Auxiliary Fun Night, a well-received evening of entertainment by members of the auxiliary and their families. I have advised the committee and concurred with its requests to plan an Art and Hobby Show for the Annual Meeting and to provide hostesses for the exhibitors at the Alcazar.

I conferred often with the Faculty's Executive Secretary to complete the membership project begun last year wherein the Faculty's president sent letters to those physicians' wives who were not auxiliary members in order to encourage membership in the auxiliary. With the cooperation and able assistance of county membership chairmen, I am happy now to report that this project gleaned 43 new members.

I prepared and edited articles for the Auxiliary Page of the *Maryland State Medical Journal* and proof-read the auxiliary newsletter *Hygeia Filiae*.

I have prepared agendae for, issued the call to, and presided over four Board meetings (having had the pleasure of entertaining the members at my Ocean City summer home for the first meeting), and one Executive Committee meeting. I conducted the Semiannual General Meeting in Hershey, Pennsylvania in September, where we were fortunate to have as guests the Eastern Regional Chairmen for AMA-ERF, Mrs. Wilson P. Smith, and Mrs. M. Bruce Martin, both of West Virginia, who were kind enough to conduct a sale of handmade ceramics to add to our AMA-ERF earnings. I anticipate presiding over the Annual General Session and President's Luncheon in Baltimore April 2. I plan to give the presidential report at the annual convention of the Woman's Auxiliary to the AMA in Chicago in June.

I have carried on much correspondence with state officers and committee chairmen, county presidents, and national officers. I have attended auxiliary committee meetings for planning the annual convention and for revising the Handbook. I have extended invitations to presidents and presidents-elect of our neighboring state medical auxiliaries, wives of Faculty guests, and participants in our Annual Meeting and Luncheon programs. I look forward to greeting our national president, Mrs. John M. Chenault, and many other guests who have accepted the invitation to be with us.

I have prepared the program for the Annual Meeting and in so doing, devised a new format, which I hope everyone recognizes as an improvement over the format heretofore used.

I now come to the second part of my report wherein I would like to acknowledge and express my appreciation for the wonderful accomplishments you, the membership, have realized. You and your dedicated committee chairmen and component presidents are deserving of loud applause.

Your conscientious AMA-ERF chairman has inspired you to raise a significant sum of money for medical education and research. Even though, at this writing, you have not quite matched the figure raised last year, I have every confidence that in the few weeks left before Annual Meeting, you will have surpassed last year's total. From our state auxiliary treasury, we have contributed to AMA-ERF in memory of our departed national officers and in memory of departed members of our state officers' families. I should like to express to the Faculty deep appreciation for the action taken to channel all funds collected from Maryland physicians through the auxiliary AMA-ERF chairman as of November 3, 1969. This will enable the Maryland auxiliary to compete on the same basis with other state auxiliaries credited with medical society donations. It is hoped that the Faculty's altruistic decision to relinquish the honor of presenting this fund at the AMA House of Delegates will encourage us to increase our own independent efforts to raise funds for our medical schools and the Loan Guaranty Fund. State awards will be based strictly on auxiliary earnings and will not take into account the more than $15,000 contributed by Faculty members, channeled through our auxiliary, and swelling our National Auxiliary Project Award Credit.

You are to be congratulated for expanding your programs for Children and Youth, for which a state committee was instituted last year. One county auxiliary has been exemplary in its involvement in its Child Development Council and work in the Family Life and Sex Education program. Many of you have been actively working with your schools and church groups, presenting programs on drug abuse and alcohol. You have displayed your interest by continuing the battle against violence in movies, TV and radio through letters and visitation to the State Board of Movie Censors; you have continued to work toward representation at the White House Conference. Our theme for the Annual Meeting is "Youth in the Soaring '70's" and we

look forward to hearing our keynote speaker, Matthew Debuskey, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine, whose topic is "Generation Without Shadow".

You have responded superbly to the need for more medical and paramedical personnel in many ways. Over and above the financial help of $300 from our state auxiliary treasury allotted to the Future Nurses-Health Career Clubs of Maryland, scholarships and loans are provided by the auxiliaries of Baltimore, Montgomery, Prince George's, Washington, and Wicomico Counties. The Baltimore city auxiliary this year has presented five loans to students totaling $3,599. The Prince George's County Auxiliary presented three nursing scholarships totaling $1,600 and helped their medical society select winners for three more scholarships. The Allegany County auxiliary worked very diligently promoting the nine Health Careers Clubs in its county and in producing in cooperation with the Board of Education the second annual Health Fair held March 23, 1970. Harford County auxiliary has completed its slide presentation of medical and paramedical careers available in Harford County, along with a tape narration, and is presenting it to junior and senior high school students.

Many of you have promoted international health activities by extending hospitality to foreign medical personnel and by collecting sample drugs, books, used instruments, and clothing for overseas shipment. You have also continued to add to the list of interpreters for foreign speaking patients. This year, for the first time, in conjunction with our Annual Meeting, your state chairman for International Health Activities has planned an informative and entertaining evening on April 1 at the Belvedere Hotel.

Our auxiliary program this year concerned itself with the mental health of children. Our members have given financial support to mental hospitals and day care centers for retarded persons; provided transportation for patients to Mental Health clinics; contributed to "Operation Santa Claus"; given books, toys, tooth brushes, and tooth kits to institutions for mentally retarded; shown films to school children on drug abuse and alcohol; and supported their local Mental Health Associations. One auxiliary provided hostesses for the Mental Health Convention in Washington, D. C.

The interest of the auxiliary in legislation has not waned: Two component auxiliaries have traveled to Annapolis by bus to visit the Legislature and their local representatives. Another auxiliary visited with its county commissioners. Membership in MMPAC is always encouraged.

Action in community health services means recognizing the local community's needs and then doing something constructive about them, oftentimes in cooperation with other existing organizations. Our auxiliaries throughout the state have a fine record in carrying out community health services of a widely varying nature. These include participating in a Cardiac Symposium; mailing of tuberculosis Christmas seals; fighting air pollution and litter; cooperating with the Heart Association, American Cancer Society, hospital auxiliaries, and garden clubs; distributing poison control information, and staffing diabetic detection clinics.

Emphasis is constantly on increasing our membership. It is a well-known fact that the greater our number, the greater our effectiveness. Members-at-large have shown the greatest increase; much credit is due the state chairman who has arranged a "coffee" in each of the ten unorganized counties, where physicians' wives have a get-together and learn about the auxiliary, how through it they can work together to create a better image of American medicine and help foster favorable public sentiment.

We have had close rapport with the Woman's Auxiliary to the Southern Medical Association through our councilor and vice-councilor. It is noteworthy that several of our Maryland auxiliary members hold positions on the Southern Medical Auxiliary board. Since Doctors' Day is synonymous with the Southern Medical Association Auxiliary, our councilor will be happy to report that again this year we will have a record of participation by all of our county auxiliaries and many of our members-at-large. Governor Mandel's proclamation was secured and distributed widely. Besides many social functions to honor our physicians, AMA-ERF contributions were made, books were purchased, library displays were set up, and niceties extended to patients in many hospitals.

We have been fortunate to benefit from the expertise of an "almost professional" newswoman who as the editor of our newsletter, *Hygeia Filiae*, in the two issues this year has kept our members informed of our goals and accomplishments. Copies are also sent to the national officers and to leaders in the other 49 state medical auxiliaries. The Auxiliary Page in the *Maryland State Medical Journal* hopefully keeps the Faculty members abreast of auxiliary news.

Our archives have been kept current and we hope our hospitality has been ample. Due to the Baltimore newspaper strike, we have had to depend on local newspapers in smaller locales for publicity.

Due to the generosity of the Medical and Chirurgical Faculty, who has again contributed $1,000 to our working funds, we have not had to raise dues and our finances are in good order. We are indeed grateful to the Faculty for this expression of confidence in us.

Our convention chairmen have made superb arrangements for our 21st annual meeting. We are indebted to them and their committee. We are also

indebted to the Medical and Chirurgical Faculty for their continued counsel and assistance and to the staff, especially Miss Wynde, Mrs. Ritchie, and Miss Sowell for their capable assistance and advice.

I want to take this opportunity to acknowledge the pleasure I have had traveling with and conferring with your president-elect, Mrs. Raymond Yow. Getting to know her better has been one of the fringe benefits of the presidency. We are indeed fortunate to have someone as capable as Margaret to take the helm. I wish for her and her fellow board members a smoothly-running year of accomplishment.

May I express my appreciation to you, the members, for the confidence you placed in me and for the opportunity to have served the medical profession and the community in this honored capacity.

Mrs. Wallace H. Sadowsky
President 1969-'70

Mrs. Yow Named New Auxiliary President



Mrs. Raymond M. Yow

The honor conferred on me and Wicomico County today by installing me President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland is deeply appreciated, and I approach my new office with pride and humility. It has been my privilege to have Mrs. Sadowsky as my mentor and guide this past year. Her friendship and advice has been, and will continue to be, most welcome to me.

My predecessors have had challenging themes during their tenure in office which fitted the times and needs of the Auxiliary. During the past year, Mrs. Sadowsky continued the national theme "Accent On Youth". The theme this year is "You, Your Community, And Our Youth".

Although we have entered the space age of the '70's, we are still faced with pots and pans, cleaning, and all the necessary and welcome duties of the homemaker. We, as auxiliarians, must continue to expand our individual horizons to encompass the needs of our own communities. We should take the initiative and help solve local problems. There is much truth in the axiom "Clean up your own backyard first". I am not suggesting that you are not already doing this. You are probably doing more than your share (if one can define the meaning and extent of share); but maybe you will find ways to encourage others to become involved in activities that benefit your area. Each locale has its own particular brand of problems and areas of need. All we can do to help is make every component Auxiliary aware of the programs that are available and that can be applied to the particular situation.

We have our youth soaring along on marijuana, glue, pep pills, LSD, and progressing finally to "hard line" drugs. But we also have an excellent package program on drugs and abuse that presents pertinent facts to a public that is only beginning to sense the depths of this tragic problem.

There are blood donor programs available almost everywhere. If your community doesn't have one, why not? And if it does, is it being supported? Use your talent to make Mr. and Mrs. Public understand and support the blood donor banks.

In the field of immunization, are you helping make the lives of all school children healthier? You don't have to be a nurse to help. There are other jobs concerned with this program that are just as important.

It is hoped that not too far in the future there will be audio and visual testing of young children. If and when this happens, scores of volunteers will be needed from the Auxiliary as well as other groups within the county.

We live in our communities, our husbands work hard in these communities. It would be nice if we could all participate and truly help meet the needs of our communities. There are package programs available. Use them.

As you know by now, the Bio-Medical Research Foundation has been closed and AMA-ERF is once again raising funds for student scholarships as well as helping medical schools. I do not plan to have a statewide participation project, such as Fun(d) day at the races this year. From the results of the past couple of years, I believe we have the message. I am asking you to stress your program in your

own county and to also continue to support the Christmas card sales. The state chairman will be ready to assist wherever possible. She needs but to be asked.

Encouraging our young people to enter a health career continues to be of vital importance. Be available to assist health careers clubs in your local schools.

The only way to have a successful program is to have an active membership. We always welcome new members, but somehow lose some old members along the way each year. Analyze your own organization and try to ascertain your weaknesses so that corrections can be made and all doctors' wives can be proud to belong to the Woman's Auxiliary. We have no room for petty differences or selfish motives. We are together because we have a mutual interest—we each represent medicine by merely being doctors' wives and no matter where we are, or what we say or do, someone is judging all doctors' wives by what they see in you and me.

Thank you for the honor you have bestowed on me. I will do my utmost to forward the aims and purpose of this organization and will represent you to the best of my ability.

Mrs. Raymond M. Yow
President 1970-'71

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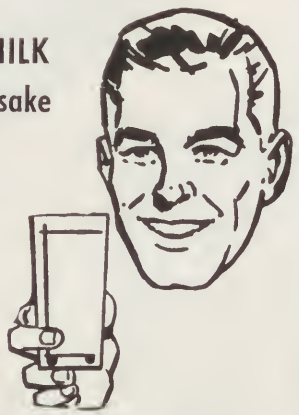
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Assistant Professor of Medicine
Director, Division of Infectious Diseases
University of Maryland School of Medicine

Infectious diseases caused by gram-negative rods have been emerging as the most common type of hospital acquired infection, as well as the most difficult to treat. Previously, *E. coli* was the most common offender but in recent years, the incidence of this has dropped and has been replaced by Klebsiella species and less common organisms like *Serratia Marscius*. New sources of organisms like humidifiers have caused gram-negative rod respiratory infections. New trends in the management of these serious illnesses will be discussed.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays: Monday, May 25, 1970 — 12:30 PM
Wednesday, May 27, 1970 — 9:00 AM
2:00 PM

MAY 29, 1970 — 12:30 PM

HEMOGLOBINOPATHIES

Julius Krevans, MD
Professor of Medicine
The Johns Hopkins University Schooi of Medicine

The relationship between the genetic control of protein structure and the biological function is nowhere better illustrated than in the abnormality of erythrocytes known as the hemoglobinopathies. Examples will be chosen to illustrate a continuous chain from molecular change to manifestations of disease.

Sponsor: PROVIDENT HOSPITAL

Replays: Monday, June 3, 1970 — 12:30 PM
Wednesday, June 5, 1970 — 9:00 AM
2:00 PM



MEDIC 1969-1970 STANDARD WEEKLY PROGRAM SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8						PEDIATRIC GRAND ROUNDS J.H.H.
9			LECTURE REPLAY			
AM 10						
11						MEDICAL GRAND ROUNDS J.H.H.
11:30		MEDICAL GRAND ROUNDS U. OF M.				
NOON 12			C.P.C. J.H.H.			
12:30	LECTURE REPLAY				MEDIC LECTURE	
1						
1:30						
2			LECTURE REPLAY			
3						
PM 4						
5						
6						
7						
8						
9						

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

May 26

POSTGRADUATE PROGRAMS presented through Medical Education's Dedicated Instructional Channel

Supported in part by a grant from Merck Sharp and Dohme

(See page 98 for a list of participating hospitals).

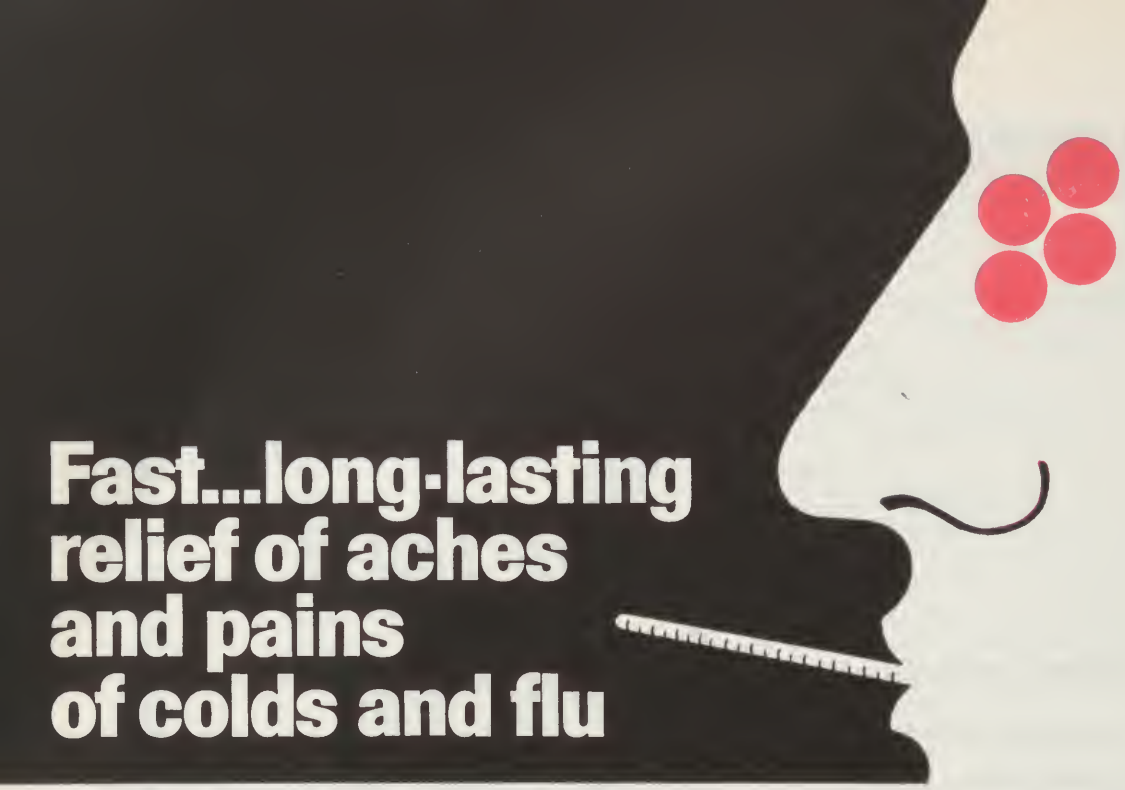
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Children: One-half the adult dose.

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Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Side Effects: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use Immediately. Acute urinary retention may be precipitated In prostatic hypertrophy.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

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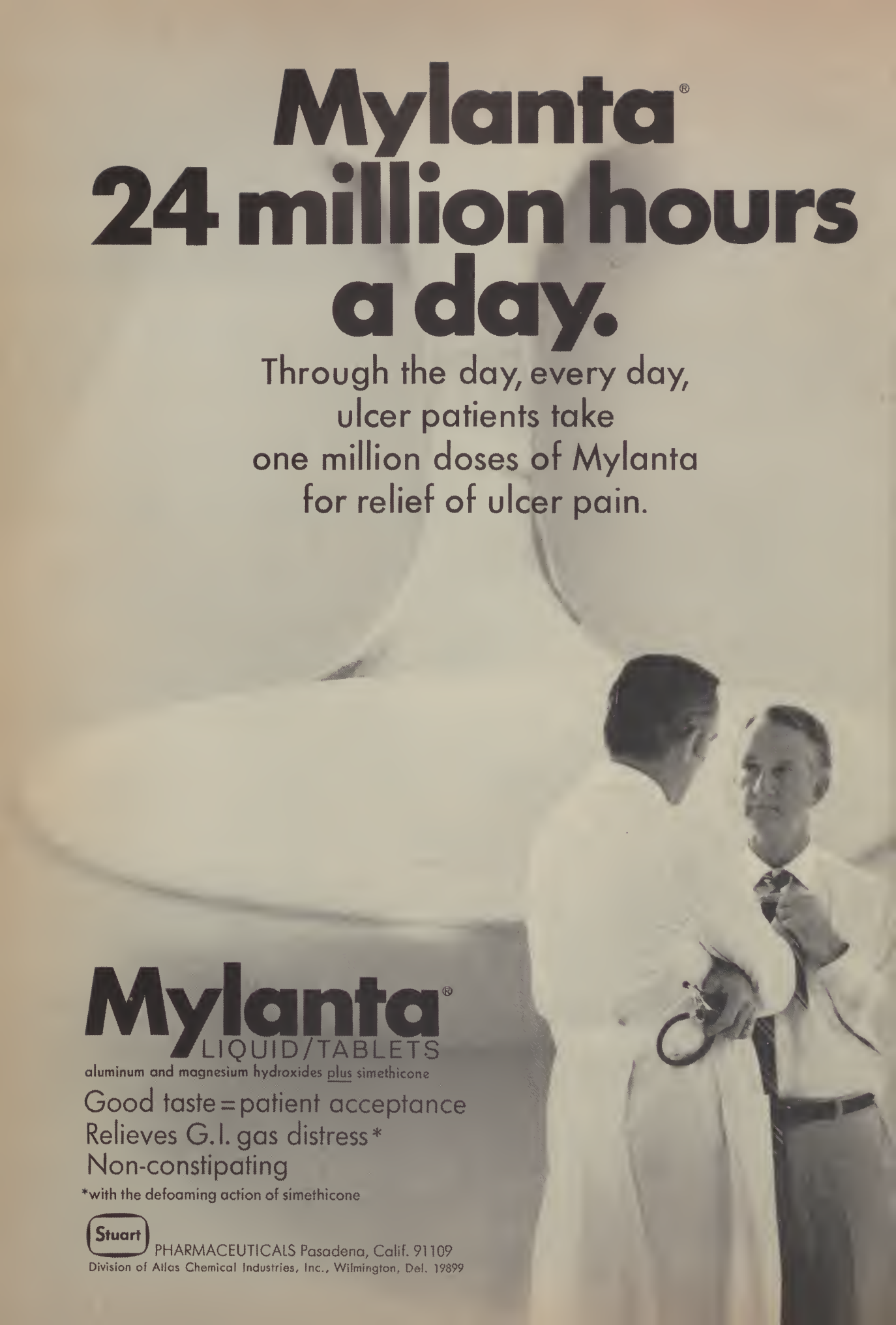
References: (1) Sands, R. X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M. J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest. Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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Emergence of Gram-Negative Pharyngeal Flora in Hospitalized Patients

Rise in gram-negative flora in the pharynx correlated much more closely with severity of illness than with hospital exposure. Concomitant diminished clearance of bacteria among the critically ill suggests mechanism of pathogenic infiltration of the lungs.

Pneumonia due to gram-negative bacilli still poses a major threat to hospitalized patients. Numerous investigations into the spread of nosocomial bacterial pneumonia have failed to uncover a pathogenic flora unique to a hospital setting, or to identify common pathogens in the hospital environment. These findings suggest that the infecting agents are endogenous to the patient.

Most pathogens probably migrate from the oropharynx into the lungs. Mechanism of entry may be by aspiration of pharyngeal fluid into the lungs. This phenomenon is known to occur in healthy persons during sleep. Thus, gram-negative bacilli in the oropharynx could possibly serve as a harbinger of nosocomial pneumonia.

The present study was undertaken to ascertain the prevalence of gram-negative bacilli in the oropharynx of normal subjects and hospitalized patients with illnesses of varying severity.

Five groups of adult subjects were selected for study. These included 82 nonhospital-associated normal subjects (firemen), 47 hospital-associated normal subjects (physicians and hospital-ward personnel), and 20 physically normal hospitalized psychiatric patients. Also included were 81 moderately ill hospitalized patients on the orthopedic-surgery service and 23 critically ill patients on the medical service. None of the normal subjects had received antibiotics for two weeks before the culture period.

Oropharyngeal cultures were obtained with an area-sampling device, and the isolated pathogens identified by standard technics.

Colonization of Bacilli

On the first culture, prevalence of gram-negative bacilli was shown to be the same (2%) for the nonhospital and the hospital-associated subjects despite a gradation in exposure to the hospital environment from none to intermittent. No bacilli were isolated from the 20 hospitalized psychiatric patients.

At the same time, prevalence of gram-negative bacilli was striking for the moderately ill (16%) and for the severely ill (57%).

Repeated cultures, however, showed a cumulative percentage rise for all five groups, including a 6% rate of positive cultures for the psychiatric group. Throughout the study, a wide divergence prevailed between physically normal and sick subjects. Cumulative percentage of positive cultures rose to only 6% for normal subjects, in contrast to a high of 35% for the moderately ill and 73% for the moribund. Overall percentage of positive cultures in each group remained essentially the same.

This study showed some correlation between the rise in gram-negative bacilli and exposure time in the hospital environment. Much more pronounced, however, was a correlation between the prevalence of pathogens and severity of illness. Nineteen per

Waldemar G. Johanson, MD; Alan K. Pierce, MD; and Jay P. Sanford, MD. *The New England Journal of Medicine* (Vol. 281, No. 21), November 20, 1969.

cent of moderately ill and 55% of moribund patients had positive cultures within 96 hours of admission. Frequency of Serratia and Proteus genera of bacteria was much lower for the moderately ill than for the moribund. Serratia was isolated in one (1%) of the moderately ill and nine (26%) of the moribund; Proteus, in none of the moderately ill, but in eight (24%) of the moribund.

Bacilli on the Move

Several studies reveal that bacteria in the upper respiratory tract frequently migrate into the lung. Pneumococci instilled in the nose of nonanesthetized rabbits appeared in the lung within minutes. When tracheobronchial clearance is impaired in dogs after a bronchus has been occluded with a piece of sterile cotton, pharyngeal organisms can be readily recovered distal to the occlusion.

In human studies, bronchoscopic specimens taken from the bronchi of a normal person usually are sterile on culture, while specimens from a person with bronchopulmonary disease contain pharyngeal flora.

Furthermore, autopsies have established that bacterial flora in the pharynx may also be found in the lungs. Whereas this finding has been attributed to agonal aspiration of pharyngeal content, it can just as reasonably be attributed to terminal failure of the clearance mechanism.

Previous studies have revealed that gram-negative bacilli are not frequently found in the pharyngeal cultures from normal subjects. The present study has shown that to be the case while emphasizing that the prevalence of gram-negative bacilli among sick patients is strikingly increased.

Intense exposure of the respiratory tract to gram-negative bacilli may occur when contaminated aerosols are generated by inhalation therapy equipment. However, some studies show that even under these circumstances only a small percentage of persons exposed become colonized, and necrotizing pneumonia due to gram-negative bacilli is infrequent. Furthermore, massive exposure of normal subjects to these organisms does not result in colonization of the upper respiratory tract.

During the course of this study some aerosol medications were found to be contaminated with Serratia. Colonization did not occur in the ten moderately ill patients who received these medications, but did occur in six of 18 moribund patients who received the same medication. Environmental contamination with other bacilli was not demonstrated and the observed prevalence of bacilli in pharyngeal cultures could not be explained on this basis.

Some studies suggest that antibiotics remove a major barrier to gram-negative colonization by suppressing the normal pharyngeal flora, which may suppress the growth of nonresident species. In this study, however, antibiotic therapy appeared to have no significant effect.

Of all the factors examined, appearance of gram-negative flora correlated most closely with clinical severity of illness. These findings suggest that the ability of sick patients to remove or clear exogenous bacteria from the pharynx is impaired. Susceptibility to gram-negative bacterial pneumonia may be increased by such colonization of the pharynx alone. More likely, it is enhanced by a concomitant impairment in pulmonary clearance mechanisms as well.

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Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

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PAUL F. GUERIN, MD, CHAIRMAN
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Librarian

library

Catalog Revisions

The spring meeting of the Medical and Chirurgical Faculty came early this year, unlike the season itself. And, as happens every year, the titles the physicians want seem frequently to just happen to be those in circulation, or those left at the library, or those that this library does not own. Try as we do, we cannot hit the nail on the head every time. Our greatest aspiration is that every Faculty member attending the annual meeting would visit the library booth to browse and get acquainted with the staff and the services the library offers.

* * * * * *

Since February, with the addition of Mrs. Judith Pochciol to the library staff, our card catalog has become a 'divided' catalog, with authors and titles in one section and subjects in the second section. The catalog has grown through years of varying systems of cataloging and classifications (now three —Noyes, LC, and NLM) and many discrepancies showed up during this process. Subject cards were typed as if titles and vice versa, adding immeasurable difficulty to the sorting procedure. Flagrant differences were corrected during the change-over, and notes were made to return to areas needing extensive revisions. This entire operation was a big step toward cleaning up the catalog, pointing up the lack of cross references, discovering the need for chronological arrangement of many subjects, and giving us a good overall look at the catalog as a library tool.

With this chore accomplished, we can now proceed with the normal tasks of book selecting, ordering, and cataloging which have been somewhat limited for the past five or six months. However, since there was no increase in budget this year, activities will be further restricted in a number of areas. The compiling of bibliographies will necessarily be curtailed greatly due to lack of adequate staff. This in turn will mean that physicians will have to use the library facilities personally to search Index Medicus, Excerpta Medica, and other literature sources. The alternative will be that the searching will be done by an outside paid literature searcher, the physician's secretary, or a library staff member for a fee (except at present there is no staff member available!).

History of Medicine

In the course of his extensive weeding of the stacks, our consultant, Lee Ash, recently drew our attention to two unusual volumes published in London in 1825. These are the *Collections From the Unpublished Medical Writings of the late Caleb Hillier Parry, MD, F.R.S.,&c.*

There are five entries for Parry's writings in Garrison and Morton's bibliography of the classic works of medicine (1954), and among them three references to this set: First (G/M2210), to the set itself, which is very scarce. Mr. Ash recalls having seen it very seldom in 30 years' experience (curiously, Welch Medical Library also has a set). Second (G/M3813), which is "a classical account of exophthalmic goitre. Although Graves and Basedow have both been credited with the first description of the condition, giving their names to it, Osler has called attention to the priority of Parry's claim . . ."; third (G/M4522), cites Parry's as the first to record cases of facial hemiatrophy. In 1816 Parry wrote on the causes and varieties of arterial pulse (G/M2742), and earlier, in 1799, had published his *Inquiry Into the Symptoms and Causes of the Syncope Anginosa, Commonly Called Angina Pectoris,* originally read as a paper in 1788, a truly remarkable scientific work (G/M2888), "concluding that disease of the coronary arteries is the responsible factor in angina pectoris. He was the first to observe the slowing of the heart rate following pressure on the carotid artery". The library does not have the book on arterial pulse, but the other volumes make fascinating reading for the clinician.

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Advances in biomedical engineering and medical physics. v. 1- 1968- . New York, Interscience Publishers.

Albert, Adrien
Selective toxicity and related topics. 4th ed. London, Methuen, 1968.

American Public Health Association. Program Area Committee on Child Health.
Services for children with communicative disorders; a guide for public health personnel. Prepared jointly by the Program Area Committee on Child Health of the American Public Health Association and the Children's Bureau, Social and Rehabilitation Service, Dept. of Health, Education, and Welfare. New York, 1967.

Baumrucker, George O.
TUR: transurethral prostatectomy; technique, hazards, and pitfalls. Baltimore, Williams & Wilkins, 1968.

Brazier, Mary A. B.
The electrical activity of the nervous system: a textbook for students. 3rd ed., Baltimore, Williams & Wilkins, 1968.

Burford, Thomas H.
Cardiovascular surgery; current practice. v. 1- . Ed. Thos. H. Burford and Thos. B. Ferguson. St. Louis, Mosby, 1969-.

Burian, Frantosek
The plastic surgery atlas. New York, Macmillan, 1968.

Cameron, Donald E.
Psychotherapy in action. New York, Grune & Stratton, 1968.

Clarke, E. G. C., ed.
Isolation and identification of drugs in pharmaceuticals, body fluids and postmortem material. London, Pharmaceutical Press, 1969.

Cureton, Thomas K.
The physiological effects of exercise programs on adults. Springfield, Ill., Thomas, 1969.

DeLand, Frank H.
Atlas of nuclear medicine. By Frank H. DeLand and Henry N. Wagner, Jr. With the assistance of Wendy A. North. Philadelphia, Saunders, 1969.

Donlon, Thomas F.
Development of the brief test of literacy; a description of the development of a new test of literacy capable of providing information concerning the prevalence of illiteracy in large sample populations. By Thos. F. Donlon, W. Miles McPeek, and Lois R. Chatham. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, 1968.

Douglas, Adrian P.
A short textbook of kidney disease. By Adrian P. Douglas and David N. S. Kerr. Philadelphia, Lippincott, 1968.

Drugs of choice, 1970. St. Louis, Mosby. W. Modell, Ed.

Early, Paul J.
Textbook of nuclear medicine technology. By Paul J. Early, Muhammad Abdel Razzak, and D. Bruce Sodec. St. Louis, Mosby, 1969.

Froelich, Robert E.
Medical interviewing; a programmed manual. By Robt. E. Froelich and F. Marian Bishop. St. Louis, Mosby, 1969.

Gastrointestinal radiation injury; report of a symposium held at Richland, Wash., Sept. 25-28, 1966. M. F. Sullivan, Ed. Amsterdam, Excerpta Medica Foundation, c1968.

Gasul, Benjamin M.
Heart disease in children; diagnosis and treatment. By Benjamin M. Gasul, René A. Arcilla, and Maurice Lev. Philadelphia, Lippincott, 1966.

Gradwohl, Rutherford B. H.
Gradwohl's legal medicine. 2d ed. Ed. Francis E. Camps, with assistance by members of the Dept. of Forensic Medicine, London Hospital Medical College. Bristol, Wright, 1968.

Haas-Posthuma, J. H. de
Infant loss in the Netherlands. By J. H. de Haas-Posthuma and J. H. de Haas, Washington, U.S. Public Health Service, 1968.

Hardin, James W.
Human poisoning from native and cultivated plants. By James W. Hardin and Jay M. Arena, Durham, N. C., Duke University Press, 1969.

Health Insurance Institute
Source book of health insurance data. New York, 1969- .

Holman, Emile
Abnormal arteriovenous communications; peripheral and intracardiac, acquired and congenital. 2nd ed. Springfield, Ill., Thomas, 1968.

International Conference on Malnutrition, Learning and Behavior, MIT, 1967. **Malnutrition, learning, and behavior; proceedings.** Ed. Nevin S. Scrimshaw and John E. Gordon. Cambridge, M.I.T. Press, 1968.

Jaffe, Norman S.
The vitreous in clinical ophthalmology. St. Louis, Mosby, 1969.

Legal Medicine Annual, 1969-
New York, Appleton-Century-Crofts, 1969- .

LeGrand, Yves
Light, colour and vision. Approved translation, from the French, by R. W. G. Hunt, J. W. T. Walsh, and F. R. W. Hunt. 2d ed. London, Chapman & Hall, 1968.

Lloyd, Wyndham E. B.
A hundred years of medicine. 2nd ed. London, Duckworth; New York, Humanities Press, 1968.

Luce, Gay G.
Insomnia; the guide for troubled sleepers. By Gay Gaer Luce and Julius Segal. Garden City, N.Y., Doubleday, 1969.

McGregor, Ian A.
Fundamental techniques of plastic surgery and their surgical applications. 4th ed. Edinburgh, Livingstone, 1968.

Nelson, James H.
Atlas of radical pelvic surgery. New York, Appleton-Century-Crofts, 1969.

Nelson, Waldo E.
Textbook of pediatrics. Ed. Waldo E. Nelson. Associate eds. V. C. Vaughan and R. J. McKay, with collaboration of 78 contributors. 9th ed. Philadelphia, Saunders, 1969.

Neurobiology of cerebellar evolution and development; proceedings of the First International Symposium of the Institute for Biomedical Research, American Medical Assn., Education & Research Foundation. Ed. R. Llinas. Chicago, A.M.A., 1969.

Nowlis, Helen
Drugs on the college campus. Garden City, N.Y., Doubleday, 1969.

Ophthalmology; proceedings of the Centennial Symposium, Manhattan Eye, Ear and Throat Hospital. Ed. Arnold I. Turtz. St. Louis, Mosby, 1969. [Symposium held in New York, June 3-7, 1968.]

Otolaryngology; proceedings of the Centennial Symposium, Manhattan Eye, Ear and Throat Hospital, v. 2. Ed. Wm. F. Robbett. St. Louis, Mosby, 1969.

Pan American Congress of Rheumatology. 4th, Mexico, 1967. **Abstracts of free communications.** Amsterdam, Excerpta Medica Foundation, 1967.

Plastic and Maxillofacial Trauma Symposium. Walter Reed General Hospital, 1967. **Proceedings,** Ed. Nicholas G. Georgiade. Coeditors: John Marquis Converse, and others. St. Louis, Mosby, 1969.

Rowe, Richard D.
The neonate with congenital heart disease. By Richard D. Rowe and Ali Mehrizi. Philadelphia, Saunders, 1968.

Rubin, Ira L.
Treatment of heart disease in the adult. By Ira Lloyd Rubin, Harry Gross, Sidney R. Arbiet, and Duncan E. Hutcheon. Philadelphia, Lea & Febiger, 1968.

Sadove, Max S.
Electroencephalography for anesthesiologists and surgeons. By Max S. Sadove, Dorothy Becka, and Frederic A. Gibbs. Philadelphia, Lippincott, 1967.

Schwabe, Calvin W.
Veterinary medicine and human health. 2nd ed. Baltimore, Williams & Wilkins, 1969.

Shepherd, John A.
Surgery of the acute abdomen. 2nd ed. Edinburgh, Livingstone, 1968.

Shimkin, Michael B.
Science and cancer. [Washington] U.S. Dept. of Health, Education & Welfare, National Cancer Institute, 1969.

Spitzer, Stephan P.
The mental patient; studies in the sociology of deviance. Compiled by Stephan P. Spitzer and Norman K. Denzin. New York, McGraw-Hill, 1968.

Steinbach, Howard L.
The endocrines. By Howard L. Steinbach and Hideyo Minagi. Chicago, Year Book Medical Pub., 1969.

Stone, Hannah M.
Drs. Hannah and Abraham Stone's A marriage manual; the famous guide to sex and marriage recommended by doctors and educators. New ed. rev. by Gloria Stone Aitken and Aquiles J. Sobrero. New York, Simon and Schuster, 1968.

Storey, Patrick B.
Continuing medical education, a new emphasis. By Patrick B. Storey, John W. Williamson, and C. Hilmon Castle. Chicago, A.M.A., 1969?

Swiss Society of Plastic and Reconstructive Surgeons.
Reconstructive surgery of thermal injuries and other subjects. Discussed at the second annual meeting of the Swiss Society of Plastic and Reconstructive Surgeons, Zurich, Nov. 4-5, 1966. Ed. F. Andina. Amsterdam, Excerpta Medica, 1967 [1968].

Symposium on cancer of the head and neck; total treatment and reconstructive rehabilitation. Ed. John C. Gaisford. St. Louis, Mosby, 1969.

Symposium on ocular therapy. Ed. Irving H. Leopold. St. Louis, Mosby, 1969. Information presented at the drug symposium of the American Academy of Ophthalmology and Otolaryngology and the Assn. for Research in Ophthalmology held in Chicago, 1968.

Taber, Ben-Zion
Proving new drugs; a guide to clinical trials. Los Altos, Calif., Geron-X, 1969.

Tolbutamide after ten years. Proceedings of the Brook Lodge Symposium, Augusta, Michigan, March 6-7, 1967. Eds. W. J. H. Butterfield and W. van Westering. Amsterdam, Excerpta Medica Foundation [1967].

U.S. Advisory Committee on Obstetrics and Gynecology
FDA report on the oral contraceptives. Washington, 1966.

U.S. National Center for Health Statistics
Health resources statistics: health manpower and health facilities, 1968. Washington, 1968.

U.S. Social Security Administration. Bureau of Health Insurance
Directory of medicare providers and suppliers of services: hospitals extended care facilities, home health agencies, out-patient physical therapy and independent laboratories. Title XVIII, Health insurance for the aged. [4th ed. Washington, U.S. Govt. Printing Office] 1969.

Wright, Logan
Bibliography on human intelligence; an extensive bibliography. Chevy Chase, Md. U.S. National Clearinghouse for Mental Health Information, 1969.

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I want to compliment you upon the recent changes in the *Maryland State Medical Journal* under your editorship. The covers by local artists are most attractive. The Table of Contents is impressive in appearance as are the format and articles, as well as the content of the items of medical interest.

The Journal has come a long way in recent years, and I am pleased to see it continue to progress under your supervision.

Sincerely,
Sidney Schleris, MD

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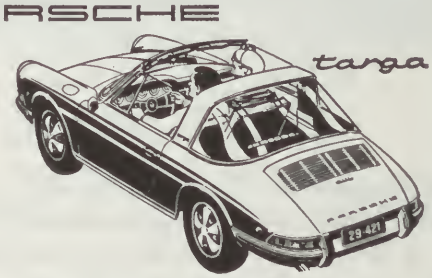
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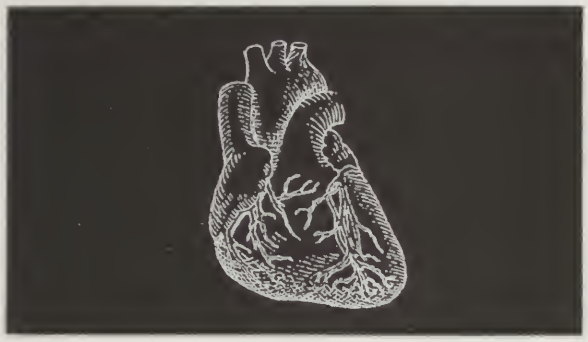
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JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Newer Concepts in Bundle Branch Block

ROBERT R. MONTGOMERY, MD, FACC
Bethesda

Recently, several investigators have demonstrated that there are actually three major branches of the bundle of His. These are the right bundle and two major divisions of the left—anterior and posterior. Conduction may be impaired or blocked along any of these fascicles and such abnormalities may be transient or permanent.

Complete block of all three fascicles (trifascicular block) closes all avenues of conduction between the atria and ventricles. This produces complete A-V block with the pacemaker driving the ventricles located distal to the bundle branches (idioventricular). This differs from complete A-V block due to disease in the A-V node or in the junction between the atria and A-V node in one major respect; namely, that nodal block allows escape of a nodal pacemaker to drive the ventricles, whereas trifascicular block demands that a lower, ventricular pacemaker drive the ventricles. The usual rate of nodal pacemakers is between 40 and 60, whereas the rate of ventricular pacemakers is often in the 20's or 30's. Hence, the heart rate is usually slower with trifascicular block. We now recognize that many cases of complete A-V block actually represent trifascicular block, especially those cases in which the ventricular rate is very slow with cerebral (syncope), renal, or cardiovascular (congestive failure) evidence of inadequate cardiac output. These cases are usually unresponsive to pharmacologic attempts at increasing the heart rate, and require pacing.

Trifascicular blocks present characteristic electrocardiographic changes. Complete block of the right bundle alone, for example, produces the well-known picture of right bundle branch block. Block of both divisions of the left branch gives classical left bundle branch block. Block of the anterior division of the left bundle (anterior hemiblock) produces abnormal left axis shift; block of the posterior division (posterior hemiblock), abnormal right axis shift. Combinations can also be recognized: Right bundle branch block with left axis shift signifies RBBB and left anterior hemiblock, right bundle branch block with right axis shift signifies RBBB and left posterior hemiblock. (In identifying these patterns, use the first 0.08 to 0.10 seconds of the QRS to determine the electrical axis.)

The PR interval must be considered, as well as the QRS, in full evaluation of trifascicular blocks, since it will reflect the status of conduction through the remaining fascicle if two are blocked. That fascicle will then represent the only communication between atria and ventricles. If conduction through it is normal, there should be no delay in atrioventricular conduction, and the PR interval will be normal (if there is no coexisting disease in the A-V node itself). If, however, conduction through this third fascicle is impaired, then there will be delayed conduction between the atria and ventricles, and the electrocardiogram will show a prolonged PR interval. As conduction through this remaining fascicle is progressively impaired, the PR interval will become progressively longer. If conduction becomes completely blocked, there will then be complete A-V block. Hence, in a patient with right bundle branch block, left axis shift, and first degree A-V block, we may conclude that there is block in the right bundle and in the anterior division of the left bundle along with impaired conduction in the posterior division of the left bundle or in the A-V node itself.

Recognition of these various types of trifascicular

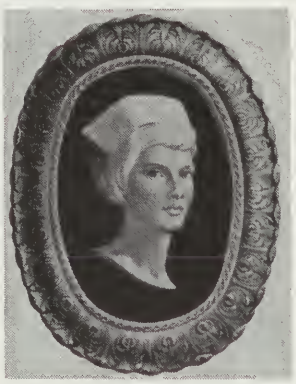
block is of greatest importance in two classes of patients: first, those with acute myocardial infarction; and second, older patients with syncope. Both groups of patients tolerate low cardiac output very poorly. Output is a product of stroke volume and heart rate; hence, slower rate demands larger stroke volume to maintain constant output. These patients, however, often do not have the ability to increase stroke volume satisfactorily; so if rate falls enough, output may become inadequate. Such slow rates accompany complete trifascicular block. Hence, if we can foresee the development of complete block during the progress of trifascicular block, we can prevent the slow rate by instituting demand pacing. For instance, a patient with anterior myocardial infarction who develops right bundle branch block with left axis shift (left anterior hemiblock) is then conducting only through the left posterior fascicle. Any further septal damage might impair conduction there too, first producing PR prolongation, then complete A-V block with a slow ventricular rate. Hence, we would introduce demand pacing as a prophylactic measure. We have seen this progression occur in a matter of minutes in some patients, so we institute demand pacing as soon as we recognize involvement of two of the three fascicles. We have found that waiting for involvement of the third (PR prolongation) has occasionally turned a serious situation into an extremely dangerous emergency.

In older patients with syncope, evidence of block of two of the three fascicles implies that if conduction fails intermittently in the third, there will be a sudden drop in heart rate with a drop in cardiac output. This mechanism appears to be the cause of a progressively larger percentage of Stokes-Adams attacks as we learn more about recognizing it. In this situation, any prolongation of the PR interval is an indication for demand pacing. If vagal stimulation causes more change in the PR interval or produces a higher grade of A-V block, demand pacing should be undertaken promptly.

In summary, we are now armed with the knowledge that there are actually three major divisions of the bundle of His, that conduction may be blocked in any one, two, or all three, that conduction may be impaired as well as completely blocked, and that these conduction abnormalities may be (usually are) intermittent. Disturbances in the conduction through these three divisions is referred to in current medical literature as "trifascicular block". We are learning to recognize the electrocardiographic representation of various forms of trifascicular blocks, and are recognizing their clinical implications.

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Baltimore City health department

Summary of Reported Poisonings in Baltimore City, 1969 and 1968

The following tables summarize poisonings in Baltimore as reported by 22 accident rooms of Baltimore hospitals and pediatric clinics. This report is made possible through a poison control ledger system maintained by the Bureau of Food Control in the Baltimore City Health Department and cooperating medical units. The figures in the tables are exclusive of poisonings treated by physicians in home and office visits or those treated at home, or those that received no treatment at all.

Table 1: TOTAL POISONINGS 1969 AND 1968 AS REPORTED BY 22 BALTIMORE HOSPITALS AND CLINICS

	1969	1968	Change
Total Cases	4,285	3,775	+ 510
Total Deaths	67	43	+ 24
Cases by Categories of Substances			
Internal Medicines	2,787	2,555	+ 232
Household Preparations	983	840	+ 143
External Medicines	108	108	None
Plants	67	30	+ 37
Gases	37	18	+ 19
Veterinary Medicines	16	7	+ 9
Miscellaneous	287	217	+ 70

Table 2:

INTERNAL MEDICINE

POISONINGS 1969

Aspirin	852
Sedatives	849
Narcotics	178
Stimulants	22
Psychopharmaceuticals	20
All Others	666
TOTAL	2,587

Table 3: POISONINGS FROM HOUSEHOLD PREPARATIONS 1969

Cleaning Products (oven, drain, bowl cleaners)	201
Washing Products (soaps, detergents)	180
Pesticides (rodent, insect, weed killers)	170
Paints, Lacquer, Solvents (turpentine, thinners, paints)	146
Petroleum Products (lighter fluid, gasoline)	105
Cosmetics (lotions, creams, mascara)	111
Polishes (furniture, metal polishes)	70
TOTAL	983

Table 4:

POISONINGS BY AGE GROUPS 1969 AND 1968

Age Group	1969	1968	Change
Under 1 year	69	69	None
1-4 years	2,295	2,169	+ 126
5-14 years	272	205	+ 67
15-24 years	755	588	+ 167
25 and over	781	669	+ 112
Age unknown	113	75	
TOTAL	4,285	3,775	

As noted above, internal medicines are the major poisoners, and children are the chief victims. Aspirin is still the single chief offender. Cases of aspirin poisonings reported in 1969 totalled 852, or a total of 76 fewer cases than 1968.

Also noted is a rise of 174 cases in drug abuse poisonings—1,069 reported in 1969 compared with 895 in 1968. These poisonings include sedatives, narcotics, stimulants, and psychopharmaceuticals. While poisoning deaths for Baltimore city numbered 67, as noted in Table 1, a total of 59 persons died of overdoses of narcotics or sedatives. This represented 19 more deaths from these causes in 1969 than in 1968.

Poison prevention educational materials are available from the Bureau of Health Information, telephone 752-2000, extension 843. A city-wide educational effort, alerting the public to accidental poisonings and their prevention, was conducted in March during National Poison Prevention Week. The Poison Prevention Committee is comprised of representatives of the Baltimore City Medical Society, the Medical and Chirurgical Faculty, the Maryland Academy of Pediatrics, the Maryland Pharmaceutical Association, the Baltimore Safety Council, the U.S. Food and Drug Administration, the Baltimore City Health Department, and the Maryland State Department of Health.

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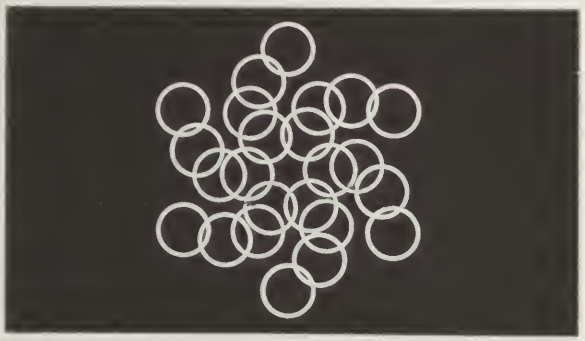
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

The Pharmacological Approach To Alcoholism—*Part 2*

STANLEY E. GITLOW, MD
Associate Clinical Professor of Medicine
Mount Sinai Medical School
New York

Now let us consider the nature of addiction. Addiction is a circumstance in which a drug has been utilized and is now gone from the body, but has resulted in an organic, measurable, overt disease state, a condition which demands more of the drug in order to get relief. This does not necessarily mean the individual is habituated or emotionally dependent, but just that he is measurably sick after the drug is gone, and he requires more of it for relief. Alcoholism was for years mistakenly considered to be an habituation, but alcohol is a true addicting substance, as is every one of the aliphatic sedatives or soporifics. Now what is cross-addiction? This simply means that among this group of sedative drugs, I can replace one with any other at any time. I can replace alcohol with phenobarbital, phenobarbital with pentothal, pentothal with paraldehyde, paraldehyde with chloral hydrate, and if I adjust the dosage correctly and give it parenterally, the individual will probably not know which he is getting, because the effect upon the brain is almost identical. Hence, there is cross-addiction among the different members of this group of compounds, but there is not cross-addiction between these and narcotics. Both sedatives and narcotics are capable of addicting but these addictions are separate disease states. **Of course, one individual can become addicted to both groups of compounds, but this is rare. We don't know why, but it is unusual to find an alcoholic who is also a narcotic addict, or vice versa.**

The withdrawal state from narcotic drugs is less severe than withdrawal from sedatives. Addicted individuals rarely, if ever, die from narcotic withdrawal, whereas death from alcohol (or other sedatives) withdrawal is quite common. Secondly, an individual who is taking a new dose of sedative to control the psychomotor agitation caused by yesterday's intake is not a well-functioning human being. He is either close to sleep or he is very uncomfortable and functioning poorly. On the other hand, if narcotics are given to the narcotic addict to stop the withdrawal syndrome, he can function and he need not continue to increase psychomotor activity. A narcotic addict can be maintained on a stable amount of drug for years and can function all during that period of time. Thus, **the narcotic addict can maintain a plateau, whereas the alcoholic, due to the pharmacology of his drug, is compelled to reach beyond, losing functional capacity in the process.**

Now I would like to discuss tolerance. Suppose you take ten drinks and I take ten drinks, and within an hour I am lying asleep on the floor and you are walking around as though nothing happened. This

means that you are more tolerant of the pharmacologic effects of alcohol than I. Thus, tolerance accounts for variability of effect relative to a single dosage of a drug. There are individual differences in the rapidity with which alcohol is metabolized. In addition, if we look at one individual over his lifetime, we will find that his tolerance diminishes with age. For example, if an alcoholic is abstinent for ten years and then relapses, he will get much sicker, with less alcohol intake, than he used to. The difference is simply that his body and especially his brain are ten years older, and every year his tolerance for alcohol decreased, even though he wasn't drinking. From this point of view, **alcoholism is a self-limiting disease because with diminishing tolerance, the amount the alcoholic can drink eventually is very little and the amount of suffering he does for it is very great.** In most instances, sooner or later, the disease either kills or the alcoholic decides to stop drinking. Our job is to try to convince him to quit before it seriously disables him.

So far, we have discussed true tolerance, tolerance to both the sedative and the agitating effects of alcohol. There is another phenomenon often described as tolerance, which refers to current sedation being countermanded by agitation from past drinking, and which really is not tolerance at all. Take, for example, an alcoholic who is drinking a quart a day, and give him ten or twelve drinks. You or I would be lying on the floor, but he is not even sleeping. His psychomotor activity level from past drinking is very high and he can take a heavy load of sedation that will give him a relatively normal psychomotor level. He demonstrates the two opposite pharmacological effects of alcohol operating together, and such individuals will not infrequently be found walking around with blood alcohol levels above 0.5%, which is usually considered to be within the lethal range. These people may be driving a car, walking around, talking for hours on the telephone—but with one difference: Tomorrow they may be amnestic about the event. This is called a blackout, and people get these quite soon after they become alcoholics. Yet, there is already a considerable amount of dysfunction, of illness, in a brain which achieves a "blackout" state. It isn't that the individual forgets what he was doing; even when he was doing it, his consciousness was clouded and he did not consciously "know" what he was doing.

I want to distinguish between alcohol addiction and alcoholism, for they are not the same. One is a pharmacological term, the other a medical term for a disease state (and as indicated before, it really should be "sedativism" rather than "alcoholism"). I can produce alcohol addiction in any one of you by giving you ten drinks today, twenty tomorrow, twenty the next day and the next, and so on until I stop the alcohol and you start having seizures. You are in a withdrawal state, alcohol addicted, but that does not make you an alcoholic. The *sine qua non* of alcoholism is that the individual goes back and does it again and again, even though he suffers loss of job, loss of health, loss of family. **The definition of the disease includes not just addiction, but compulsivity.** Now why, when he suffers so much, does he do it again and again? Because he is compelled to, but not primarily because of the suffering that goes with it. He would like to find a way of avoiding the suffering and not infrequently will come to the physician asking for sedative medication that will prevent the suffering. The reasons for the compulsion to drink may be psychological. I used to think that, but now I am not so sure. These individuals may have a different psychomotor activity level on a biochemical basis. The norm for them may be higher than that for other people because of a biochemical defect within the brain, so that they do not feel like other people until their psychomotor level is artificially brought down by sedatives. This may or may not be so, but many people believe that such a biochemical defect will be shown to exist.

There is a clue in the frequent statement of alcoholics: "I had my first drink at 18, and I finally found out what it was like to feel normal. I had felt abnormal all my life until that first drink and then I felt like everybody else. If I could just maintain that level . . ." But of course an alcoholic can't. If his initial level of anxiety was already too uncomfortable, too agonizing to bear, how can he tolerate the increased anxiety from the agitating effect of the sedative? The only way he knows to relieve it is to take another drink. His decision to drink or not to drink has to be made before he takes the first one.

If you or I have a hangover after a party, it is unlikely that we are going to drink to relieve our temporarily elevated psychomotor activity level, unlikely that we are going to take a "hair of the dog", except perhaps one "Bloody Mary," and the majority of us won't even do that. Most of us will say: "I shouldn't have drunk so much and I won't do it again for a long time." We can tolerate this degree of psychomotor activity and after a few hours we begin to feel better. The alcoholic can't tolerate it and must drink again. **This is not volitional; he must drink again to relieve the discomfort which he couldn't tolerate even when it was less intense before.** It is relatively easy to understand continual drinking under these circumstances. But suppose we see this man after he has been sober six months or six years. He gets anxious, takes a drink, and in the majority of cases begins the cycle again. He can't plead ignorance and he did it while cold sober. Now when

you see this happening, there can be only two possible reasons. One is that alcoholism is a compulsive psychiatric syndrome of such a nature that his psyche is going to force him at knifepoint to drink throughout his life. The other possibility is that on a biochemical basis the alcoholic is truly uncomfortable without sedation. How much is psychological and how much is biochemical? Is the individual starting out with a normal anxiety level, or at a level higher than normal? If the psychomotor activity state can be markedly modified by drugs, as it can, how do we know it was "right" in the first place? We don't. It is quite possible that the individual has a biochemical defect to start with, which creates a fertile soil for the growth of alcoholism.

The treatment of this disease is to stop the use of the causative agent. When first seen by the physician, the alcoholic is a very agitated fellow and needs sedation, but if we sedate him, whatever we use will cause greater agitation later. The physician is in a circumstance where he's damned if he does and damned if he doesn't. Hence, Rule #1: **If you're going to have to relieve the symptoms of this alcoholic by giving him a sedative drug, you must rarely, if ever, give it outside the hospital.** Give it only in a situation where you have *complete* control of the patient and the dosage of medication. In a hospital, the physician can give some sedatives in association with phenothiazines, drugs such as chlorpromazine (Thorazine) or promazine (Sparine). These drugs will not usually prove addicting, but will increase the effects of the sedatives the physician is giving, and will enable him to relieve the patient without causing a marked increase in agitation. By the fourth or fifth day, the alcoholic will perhaps still be a little tremulous, but will usually feel well enough to go back to his job. But though the withdrawal state is at its worst for only a few days, its more subtle effects—psychological abnormality or character disorganization—may last for weeks.

Now the patient has been withdrawn from alcohol and is ready for long-term therapy for the recidivism or compulsivity that makes him start the whole cycle again, over and over again. You've got to help him build some sturdy walls before the wolf comes to blow again at his house. And you begin to appreciate the vigor and persistence necessary in therapy.

Obviously, the way to handle this individual in order to keep him from drinking again is *not* through the use of sedative drugs, because as soon as you give sedation of any sort, he begins to repeat the cycle. In fact, **the simple act of prescribing sedatives in order to relieve the anxiety symptoms of the alcoholic is the one thing that will guarantee failure almost 100% of the time.** There are, for the most part, no drugs of any great value in treating alcoholism. Chlordiazepoxide HCl (*Librium*), benzodiazepine derivative (*Valium*), meprobamate (*Miltown* and *Equanil*), and glutethimide (*Doriden*) are often used but share an undesirable propensity for being variably addicting. Remember, we noted at the outset that all of the sedative drugs are qualitatively identical and can replace one another: alcohol, barbiturates, chloral hydrate, paraldehyde. The individual develops a cross-tolerance, so that if, for example, he builds up a huge tolerance for alcohol, it will take a huge amount of ether to knock him out on the operating table, a fact which all anesthesiologists know. If you use other sedatives to treat the alcoholic, you go back and forth between the two and never solve anything—the individual remains addicted. Patients who take such drugs often get so jittery that they go back to alcohol for sedation.

The case of the phenothiazines is somewhat different. These drugs (Thorazine, etc.) work on a different part of the brain, and alcoholics usually don't like them, don't get the relief they want. Thorazine does not significantly increase the psychomotor activity level and hence is practically nonaddicting, but I believe that the person who takes it will more readily make a transfer back to alcohol than those who use no drugs. Since Thorazine doesn't give the alcoholic what he wants, he is almost bound to take something else in short order. I'm also convinced that if you give any sort of "oral magic" to an alcoholic, you are almost guaranteeing a relapse. If you give a pill (even if you fill it with sugar), you are in essence saying: "Yes, there is something wrong that is correctable by some magic taken by mouth." But the fact of the matter is, there are no sedatives or tranquilizers that do anything for this disease except cause trouble, and one should do everything possible to help patients realize that there is no magic.

Antabuse, on the other hand, has something to offer in the treatment of this disease. Antabuse is not a drug which works on the central nervous system: it does not relieve anxiety or change the psychomotor activity level of the brain. It has no effect whatever, unless the individual takes alcohol on top of it, in which case alcohol metabolism stops at the acetaldehyde stage. The acetaldehyde level builds up in the bloodstream, and it produces a toxic reaction which includes nausea, vomiting, flushing, vasomotor collapse and, in extreme cases, death. Most patients, even without trying it, will believe this. Antabuse is taken every day and gives four to five days protection against drinking.

Suggesting that a patient take Antabuse permits me to quickly gauge his degree of motivation. If he takes a negative attitude, I know the odds of

doing anything with this patient are poor. But if the patient is willing to take it, I know I have a more promising situation. Second, Antabuse stops impulsive drinking completely, because if the person on Antabuse drinks, he will be quite ill. If he comes in with a relapse, I have the opportunity to prove to him that he decided in advance to get drunk and so stopped taking the Antabuse several days ahead. I always have told him in advance that if he stops his Antabuse, it will be for one of these reasons: "I ran out and forgot to buy more"; "I forgot to take it"; "I went on a trip and forgot to pack it"; "I wanted to do it on my own and not use a crutch"; "I was so well, I thought I had no further need for it." Now, if he relapses, I have predicted these "reasons" in advance and so can help the patient see that he planned the drunk, and then we can get down to the real precipitating causes, not the phony ones.

The third thing Antabuse does is to assist patients in answering, once a day, the question of whether or not to drink. They are not preoccupied about drinking all day long, and they feel a tremendous relief, at least for a temporary period. Certainly, by itself, Antabuse is not the answer, but it is a helpful tool, and it gives the physician time to work with his patient. Some people take it for years to guarantee their sobriety, but it should be taken voluntarily and only because the individual wants to stop drinking.

In treatment, cessation of alcohol intake is the first goal. Education about the nature of the disease is essential, but most important is to bridge the alcoholic's isolation by the use of simple understanding and compassion. Usually the alcoholic has been trying to say right along (and no one in his environment has understood): "I'm strung up, I'm caught, and nobody seems to realize how violently ill, how terribly trapped I am. All people say is I just won't quit drinking or I bring it on myself." When the alcoholic becomes aware that you do understand, you may have a successful patient. With compassion and consistency, a great deal can be accomplished.

The long-term treatment of alcoholism must be directed toward increasing the abstinent alcoholic's capacity to tolerate anxiety without recourse to sedation. Obviously, he has to be given something to replace the "oral magic," and the only thing I know is a helping hand. The helping hand may be Alcoholics Anonymous or psychotherapy; it may be the clergyman, the social worker, or the physician. The alcoholic needs people who understand and are compassionate, who offer the ear, the time, and the hand to help him through his discomfort.

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JAMES E. CARSON, MD, COMMISSIONER
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Maryland State department of mental hygiene

The Long-Term Patient

Nearly half of all beds in Maryland's mental hospitals are occupied by patients who have been under continuous care in the same facility for five or more years. As shown in the following table, 62% of these 3,581 individuals were reported to be psychotic. Of the other 1,359, 29.4% were retarded, 13.8% had convulsive disorders, and 16.2% were admitted for conditions related to old age. Their average (median) age at the time of admission was 35.6 years and is now 56.6 years.

CURRENT AGE AND DIAGNOSIS	AGE AT ADMISSION TOTAL	LESS THAN 25	25-44	45-64	65 AND OVER
TOTAL	3,581	853	1,761	741	226
PSYCHOTIC	2,222	514	1,264	405	39
LESS THAN 45	373	209	164	—	—
45-64	1,078	247	686	145	—
65 AND OVER	771	58	414	260	39
NONPSYCHOTIC	1,359	339	497	336	187
LESS THAN 45	263	197	66	—	—
45-64	565	126	307	132	—
65 AND OVER	531	16	124	204	187

The reported median length of hospitalization of these patients is 21.0 years. Based on available expenditure figures for this period, this is equivalent to an average cost per person in excess of $35,000. That is, $125 million has already been spent for their care and maintenance. Currently, 7% of long-term patients are released each year with the discharge rate decreasing with increasing age and length of hospitalization. If this pattern remains unchanged, most of these individuals can be expected to remain hospitalized 15 to 20 more years until their ultimate death. On the basis of current cost trends, this represents an additional expenditure per patient exceeding $35,000.

In recent years, approximately 250 long-term patients were discharged annually, 200 died, and 300 became chronic in the hospital. As a result, the number of these patients has declined 150 per year to the lowest level in a decade, with a further decrease anticipated. In 1960, for example, there were 5,016 such patients. Efforts to accelerate this trend are dependent on the development and expansion of closely coordinated and centrally directed programs to:

1. Counter symptoms and conditions leading to long-term hospital stay. Many patients admitted for acute disturbances eventually become chronic and custodial unless continuing efforts are made to channel these individuals into a functioning, community setting.

2. Release and habilitate inpatients who have been hospitalized for extended periods. Many of these could be discharged if adequate supportive community programs such as nursing homes, day and night centers, and sheltered workshops were available in conjunction with continuing psychiatric services.

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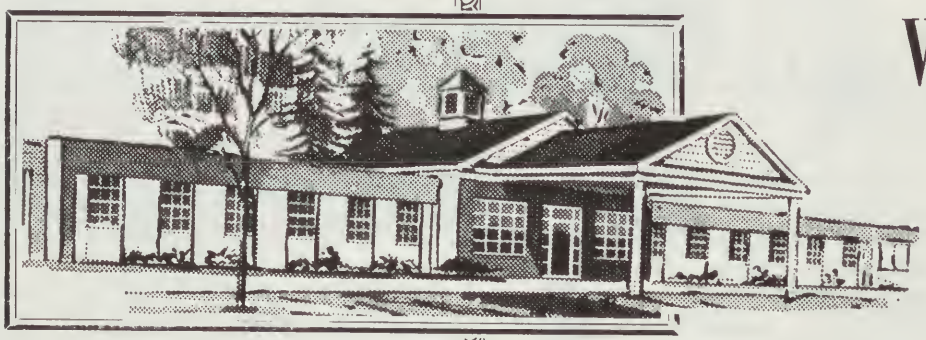
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Maryland State department of health

State School Health Council Elects Officers

John M. Krager, MD, Assistant Health Officer in the Baltimore County Health Department, has been elected to a three-year term as Chairman of the Maryland State School Health Council, an advisory group to the State Department of Education and State Department of Health. Dr. Krager, a pediatrician, has represented the Maryland Conference of Health Officers on the Council for two years.

Other officers elected to the Council are Mr. Oscar Jensen, an Associate in Higher Education with the Maryland State Teachers Association, Vice Chairman; and Miss Joan M. Wolle, Chief, Division of Health Education, State Department of Health and Mental Hygiene, Secretary.

Other members of the Executive Board and the organizations they represent are as follows:

Gladyce Bradley, PhD, Morgan State College (representing Maryland State Teachers Association Higher Education Council)

Mr. James G. Busick, Superintendent of Schools, Dorchester County Board of Education (representing school superintendents)

Robert J. Dawson, MD, a pediatrician from Cumberland (representing General Body)

Mr. Francis J. Dickson, Administrative Assistant, Department of Education, Archdiocese of Baltimore (representing Dept. of Education, Archdiocese of Baltimore)

Mrs. Robert Gaskins, MCPT Health Chairman (representing Maryland Congress of Parents and Teachers)

Mr. Richard Hartt, Specialist, Division of Child Welfare Services, State Department of Social Services (representing State Department of Social Services)

Fred J. Heldrich, MD, Director of Continuing Medical Education, State Department of Health (representing Maryland Chapter of American Academy of Pediatrics)

Frederick R. Keyton, PhD, Coordinator of Pupil Services, State Department of Education (representing State Board of Education)

Miss Pauline V. Kummer, RN, Public Health Nursing Consultant in Pediatrics, Division of Nursing, State Department of Health (representing State Department of Health)

John B. Saratsiotis, MD, Director of School Hygiene, Baltimore City Health Department (representing General Body)

Robert E. Schneider, PhD, Supervisor of Health Education and Service, Montgomery County Public Schools (representing General Body)

Mr. Frederick Sheeley, Supervisor of Special Education, State Department of Education (representing State Department of Education)

Margaret L. Sherrard, MD, Deputy Director, Baltimore County Health Department (representing the Medical and Chirurgical Faculty of Maryland)

Miss Doris E. Terry, Supervisor of Health Education, State Department of Education (ex officio)

Alice B. Tobler, MD, Director of Mental Health Planning, State Department of Mental Hygiene (representing State Department of Mental Hygiene)

Mrs. Beatrice L. Wolcott, RN, Supervisor of Nurses, Secondary Schools (representing Maryland State Nurses Association)

Formed approximately 20 years ago, the Council assists in the development of school health programs

which afford maximum health benefits to every school-age child in Maryland.

Dr. Krager stated that the Council promotes effective and comprehensive school health programs designed to provide a safe, healthful school environment; instruction in sound health and safety practices; and appropriate school health services.

The new Chairman cited some of the Council's past contributions to school health in Maryland: achievement of better communication and coordination between the State Departments of Education and Health; recommendations for revisions in the State School Health Laws; advice to the State Health Department on certain legislative proposals; development of a health appraisal form for use in schools in Maryland; and sponsorship of a statewide health education conference in 1962.

Currently, the Council is working on preparation of a school health manual for use in schools throughout the state, suggested revisions of the bylaws of the Board of Education relating to required immunizations, and plans for another health education conference to follow-up the 1962 meeting.

Chairmen and the standing committees to which they have been appointed include:

Health Services—Julius Loebl, MD, Director, Division of Maternal and Child Health, Anne Arundel County Health Department

Health Education—Herbert L. Jones, HSD, Head of Health Education, Department of Physical Education, Recreation and Health, University of Maryland

Healthful Environment—Mr. James G. Busick, Superintendent of Schools, Dorchester County Board of Education

In addition to the Executive Board, the Council includes two representatives from Baltimore city and each of the 23 counties, one of whom is appointed by the Health Officer and the other by the Superintendent of Education.

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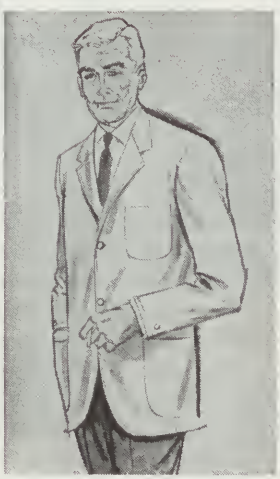
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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Illustrations of Patients With Spinal Cord Injuries

The purpose of this communication is to illustrate different problems in the management of patients with spinal cord injuries.

Unexpected Good Adjustment to Disability in a Patient with Sociopathic Personality

B.C.H. # 24 68 65, a 19-year-old boy, was shot through the spine on June 16, 1958, resulting in a complete paraplegia at T6. There was a hemopneumothorax. An emergency laminectomy revealed a frayed, blue-black cord. A catheter was placed in the bladder, and the patient was transferred to the Baltimore City Hospitals on July 15, 1958. The hemopneumothorax had disappeared. The patient had a complete physiological cord transection at T6. Over the next several months, the patient was mobilized with long leg braces. He developed a spastic bladder and was able to use condom-type drainage with a urinal bag. There was no evidence of urinary tract infection or distortion, and no reflux into the ureters on X-ray.

A remarkable change took place in this patient during treatment. Prior to the injury, he had been an irresponsible child involved with a gang of street rovers. The patient came from a lower-middle-class family and had been the "black sheep" of his family, relating poorly to his siblings. Prior to his injury, he led a semiviolent, nomadic existence and had difficulty with legal authorities. One psychologist characterized him as the "soldier of fortune" type. His parents died on the same day when he was 19 years old, his father of a heart attack and his mother of a carcinoma of the stomach. He had a ninth grade education.

After several weeks in the hospital, the patient began working very hard, was conscientious, overcame tremendous difficulties, and finally accomplished ambulation with crutches with long leg braces, despite his high lesion.

Late in 1959, the patient was accepted at the Bulova Watch Repair School on Long Island, where he completed the training course. While there, he was a member of the Wheelchair Basketball Team and participated in the Paraplegic Olympics in England. Following graduation he opened a watch repair shop. Subsequently he married, and remains self-supporting 11 years following discharge.

Comment: This patient's life style was completely changed by his spinal cord injury. Following the injury he underwent a complete personality change, fighting his disability with stubborn courage, going on to achieve complete financial independence, as well as a stable marriage, with none of the usual complications of spinal cord injury.

Partial Paraplegia in a Patient with a Sociopathic Personality With Recovery

B.C.H. # 26 21 66, a 19-year-old man, was admitted on May 4, 1959 with a crushed fracture and cord injury at L_2 to L_3. The patient was completely paralyzed in the legs when first seen in the hospital. He was unable to void. A catheter was introduced and a laminectomy performed. The cord was intact, but bruised. Thereafter, the patient was very uncooperative and hostile. The psychologist felt that he had a low frustration tolerance, poor control of his impulses, little motivation to work, and a self-defeating attitude with impulsive hostilities. It was felt that he would not benefit from any type of vocational training program and doubtful that he could maintain himself in a responsible work situation. The patient stated that if he did not get well he would kill himself. He felt that the medical procedures had injured him so that he would not recover. In April 1960, the patient lapsed into periods of unresponsiveness on a number of occasions, and no apparent cause could be found. Long leg caliber braces were obtained, and it was finally possible to get the patient

up on his feet with the help of crutches.

He was discharged in May 1960, one year after his injury, with braces, crutches, and a wheelchair.

He returned on April 13, 1961 asking for help in finding a job. Because of the psychological report, it was felt that no more could be done for him. He was registered at the State Employment Office.

In the spring of 1968, he returned, and was still using his braces and crutches. He reported that he had been holding a job at the Social Security Administration for the last two years. He had been married happily for a number of years.

Comment: It took this patient a number of years to accept his disability and try to make the most of it. Acceptance of a disability is a peculiarly personal process, and the efforts of medical personnel to help him may be spectacularly unsuccessful.

Housewife With Ten-Year Survival, Skin and Renal Complications

B.C.H. # 21 97 66, a 41-year-old married woman, was brought to the hospital on October 13, 1956 after being shot through T7 by her husband. The husband had thought she was dead and had shot and killed himself. A left pneumothorax was treated with tube suction. Laminectomy showed complete severance of the cord at T7. The patient was treated with tidal drainage and was rapidly mobilized. Over the next few months, she was able to transfer from bed to wheelchair and back; long leg braces were obtained, and the patient learned to use them well. She developed some small ulcers which healed rapidly. She was discharged and sent home, where her daughter was able to do the shopping, laundry, and cooking. Otherwise, the patient was independent.

At the end of two years, the patient was socially independent at home but was having occasional urinary tract infections. She had a small sacral ulcer which never healed completely. She had two hospital admissions for treatment of pyelonephritis in 1958. Late in 1958, she had a three-week hospital stay for closure of the ulcer. Because of an atonic bladder, a transurethral resection was attempted on September 9, 1959 to allow the patient to empty her bladder with abdominal pressure. This was unsuccessful, and on November 4, 1959 an uretero-ileo-cutaneous fistula was created. Intravenous pyelograms prior to surgery had been normal but, following operation, enlarged bilateral ureteral dilation with hydronephrosis developed. This cleared when the stoma was enlarged. The right ureter became obstructed at the anastomotic site to the ileum. Eventually the right kidney became nonfunctioning. On April 29, 1964 a revision of the right uretero-ileostomy anastomosis was performed. Following surgery there was a fecal fistula (January 8, 1965). Intravenous pyelograms thereafter showed that the right kidney remained inactive. The patient gradually lapsed into uremia and died on January 4, 1966 of uremia.

Comment: This patient made a satisfactory functional recovery, but had persistent urinary tract infections and pyelonephritis, not improved by uretero-ileo-cutaneous fistula. Attempts at revision of the uretero-ileostomy anastomosis were unsuccessful. Although the uretero-ileo-cutaneous fistula cannot be clearly identified as the cause of death, it was unsuccessful in delaying deterioration of renal function.

Septicemia, Contractures, Pyelonephritis, and Death in a Quadriplegic

B.C.H. # 35 71 65, a 49-year-old man, had a severe fall on September 24, 1962 resulting in subluxation C5 on C6 with quadriplegia. He was placed in traction at another hospital and transferred to Baltimore City Hospitals on November 21, 1962. There was no useful function in the legs or arms. The patient was seen daily on the ward in an attempt to maintain range of motion in the arms. Despite this, he developed a flexion contracture of the right elbow which was worked on daily with heat and stretching. On December 15, 1962, he developed phlebitis in the left arm secondary to repeated intravenous infusions followed by septicemia. There were intermittent febrile episodes, cystitis, and pyelonephritis. Within three months of injury the patient was thin and wasted, and had severe recurrent renal infections, decubitis ulcers, and contractures. He was unable to maintain nutrition. On February 24, 1963 the patient died, probably of septicemia.

Comment: One small complication (phlebitis) may lead to other more serious episodes (septicemia, contractures, pyelonephritis) tipping the very precarious balance of the quadriplegic, and resulting in early death.

Recovery in an Aged Patient With Multiple Diseases

B.C.H. # 32 31 10, an 85-year-old woman, fell on January 29, 1962 and suffered a dislocation of C1, secondary to a flexion-type injury. Crutchfield tongs were inserted and the dislocation was corrected. The patient had marked weakness of both upper and lower extremities on admission. She was incontinent of urine and feces. She was confused and had difficulty with language.

There was a past history of arteriosclerotic heart disease in compensation with digitalis and diuretics and an old left-hip fracture. Two months after admission, the patient was started on mobilization at which time she had an ADL score of 23 and a MSCL score of 12. The question of whether ambulation should be considered was raised since the patient had already had one fall. However, she was started in parallel bar work and over the next three

months was able to master walking with supervision. She was kept in a neck brace, taken to a walkerette, and was discharged with her neck brace, and was independent in a walker three months after her discharge.

Comment: Despite age and other disabilities, recovery of function may occur if complications can be prevented.

Quadriplegia in a Patient with Ankylosing Spondylitis

B.C.H. # 44 96 86, a 48-year-old man, was admitted on April 4, 1966 complaining of an inability to walk for 24 hours.

The patient had a long history of rheumatoid spondylitis which was treated in the past with steroids. The rheumatoid spondylitis had been slowly progressive, involving the spine from the pelvis to the skull.

Two days before admission, the patient had been involved in an automobile accident. He came to the emergency room on April 2 where a laceration of the upper lip was sutured. He remained overnight in the emergency ward and had some soreness of his neck and arm, but claimed that he had previously had these symptoms associated with his rheumatoid spondylitis. He was discharged, walked to his car, and drove home. Three hours after his arrival at home his legs gave way, and he was unable to walk. Thereafter he noted progressive paresthesias and returned to the emergency room the following day.

The patient had been able to work as a crate maker until the time of his automobile accident.

Examination showed a temperature of 102°F, P 132, R 24 and BP 130/70. The neck was flexed to 90° with pain on extension or flexion. There was very little motion present in the neck. The chest expanded poorly, and he used his abdominal muscles mainly for respiration. A few rales were noted over the left lower lung fields and tubular breathing was heard at the right base posteriorly. The bladder was grossly distended to the umbilicus. There were no bowel sounds. The patient had good biceps and triceps strength on the right, but had poor muscle strength in these muscles on the left. The left lower extremity could not be moved. The right lower extremity could be moved, but all muscles were weak. Below the umbilicus on the left, pin-prick and touch sensations were reduced. Position and vibratory sensation were intact. There was hyperflexia of the left knee and ankle. There was no clonus. The Babinski sign was positive on the left; there was no ataxia or tremor.

Chest X-rays showed a pneumonic infiltration of the left lower lobe. The lumbar puncture was normal. The blood leukocyte count was 16,250.

The patient was catheterized and a residual urine output was 900 cc. An emergency myelogram showed complete block of C5 to C6 level. He was started on intravenous penicillin and fluids.

On April 5 the patient underwent a cervical exploration, and it was found that the lamina of C5 spine was broken. There was an epidural hematoma at the C5 level. The laminectomy was extended from C4 to T1. The patient had to have a tracheostomy prior to surgery to allow proper administration of anesthesia.

The patient's weakness disappeared in the week following surgery. On April 11, over a period of several minutes, the patient noted that he could not move his right leg. He was unable to move his fingers on his right hand and his left arm became weak. Cervical X-rays showed there was a dislocation fracture of C7 on T1. Crutchfield tongs were applied, and the spinal column became realigned by April 14. He continued to improve. By April 18 the tracheal tube was removed. Further X-rays, however, showed that the alignment of the spine was not ideal. Crutchfield traction was continued and over the next month there was gradual improvement in strength. By June 16 the patient had the Crutchfield tongs removed and replaced by a neck brace. It was then possible to mobilize the patient, and he was able to be discharged ambulatory on June 17, 1966. At this time he had weakness and atrophy of the left triceps and the fingers of the left hand.

Comment: Mild neck trauma in patients with ankylosing spondylitis, as well as cervical osteoar thritis, is frequently associated with paraplegia.[1]

Quadriparesis With Cervical Osteoarthritis

B.C.H. # 37 35 25, a 53-year-old man, fell down the steps on May 10, 1963, hurt his neck, and was unable to walk. He was taken to an emergency room in an ambulance and was sent home after observation. He was admitted on May 18, 1963 with weakness in his arms and legs. He had severe cervical osteoarthritis. A myelogram showed impingement of osteoarthritic spurs on the cervical cord from C4 to C6. No fracture or dislocation was clearly identified. A laminectomy, C4 to C6, was performed with foraminectomies and stabilization of the cervical spine. The MSCL score initially was 25 and the ADL score 30. Over the next six months there was gradual return of function in the legs and bowel and bladder, and he reached an ADL score of 90 by November 1, 1963. He was able to do everything except button small buttons, wash his back, or tie his shoes. He was given elastic shoe laces. The patient was thought to have cervical spondylosis with a traumatic injury in the neck area resulting in pressure on the cord involving the lower extremities and pressure on the nerve roots of the upper extremities.

Comment: Patients with cervical osteoarthritis are particularly likely to suffer root and cord injury with moderate twisting of the neck and without fracture of vertebrae. We have seen a very similar patient, also sent out from an emergency room, who developed severe quadriparesis. One other patient developed quadriplegia following surgery, presumably secondary to hyperextension of the neck during anesthesia.

Partial Paraplegia With Improvement After X-ray and Surgery in Hodgkin's Disease

B.C.H. # 47 78 56, a 33-year-old man, was admitted on September 6, 1966 because of weakness in his legs. A diagnosis of Hodgkin's disease had been made in 1960. Since that time, he had had all available types of treatment for Hodgkin's disease. In December 1960, he had developed weakness of both upper extremities, presumably caused by cord pressure by a granuloma of Hodgkin's disease. X-radiation had completely relieved the weakness.

In March 1962, recurrence of weakness in the upper extremities and compression of the cord was demonstrated by myelograms. X-radiation again relieved the weakness of the upper extremities. In 1962, treatment with nitrogen mustard and X-ray resulted in complete disappearance of demonstrable Hodgkin's disease. He was able to return to work.

In July 1965, leg weakness, numbness, and bladder incontinence occurred and a diagnosis of lower cord compression was made. A laminectomy was performed from T5 to T8 with decompression of the dura mater. There was complete reversal of weakness, bladder symptoms, and numbness. In September 1966, there was rapid recurrence of the leg weakness, and he was readmitted. A second laminectomy from T6 to T7 with excision of a 6 x 2 cm tumor was performed on September 28, 1966. Following the operation, the strength of the legs again returned, and he was referred to the Physical Therapy Department on November 7, 1966. Over the next few weeks, he regained strength in the legs, but because of persistent mild weakness in the legs, he was discharged on crutches.

Comment: We have now seen several patients with paraplegia associated with Hodgkin's disease who have regained strength with X-radiation, drug therapy, and laminectomy.

Iatrogenic Paraplegia With Complications

B.C.H. # 42 66 06 was 16 years old in July 1959 when she delivered her first child under spinal anesthesia. Postpartem she had paresthesias in her left leg, and two weeks after delivery she developed severe thrombophlebitis in this leg which gradually became completely paralyzed. There was gradual increase in the weakness of her lower legs with development of complete paraplegia which appeared to be at T8. There was recurrent thrombophlebitis with pulmonary emboli. An inferior vena caval ligation was performed for clear-cut pulmonary emboli. At surgery, a clot was removed from the inferior vena cava. The procedure was done under continuous spinal anesthesia. Following this procedure the paraplegia became complete and stable.

In 1960, she came to Baltimore and was seen in a local hospital, where she weighed 80 lb and had severe decubitus ulcers. There was a complete paraplegia at T8. Spinal exploration in 1960 resulted in a diagnosis of adhesive arachnoiditis. She spent 15 months at a rehabilitation hospital where she was able to perform all activities of daily living from a wheelchair but, despite extensive surgery, her decubitus ulcers never completely healed. She had excision of the greater trochanter on the left, removal of the left ischial tuberosity and inferior ischial ramus for osteomyelitis. The inferior ischial and pubic rami on the right were removed. She suffered a fracture of the right trochanter thought to be secondary to mild trauma in a demineralized bone. On October 23, 1963, the patient felt her left hip snap, and X-rays showed a complete transverse fracture of the upper femur. A disarticulation of the left lower extremity with hemipelvectomy was recommended because of osteomyelitis, but the patient had a severe emotional reaction and refused surgery. In 1963, a ureteral-ilio-cutaneous fistula was performed which functioned fairly well thereafter.

In 1963, she developed severe migraine headaches and was treated with ergotamine. Shortly after this she began to have signs of vascular insufficiency in the legs and required an amputation of the left leg. Thereafter her emotional anxiety and depression increased greatly.

The patient was first admitted to Baltimore City Hospitals on January 22, 1965 because of premature labor. The baby was delivered dead. Because of a severe anemia, the patient was transferred to the medical service. She had an elaborate work-up resulting in a diagnosis of folic acid deficiency. There were decubitus ulcers over the sacral area and heels. The paraplegia below T8 was clear-cut and symmetrical.

At home she sat in a wheelchair, and was able to clean house and take care of her children. She continued to have open decubitus ulcers.

Her second admission to BCH on May 25, 1966 was for an acute pulmonary embolus.

On June 26, 1967 she was admitted for acute thrombophlebitis of the left thigh.

On September 9, 1967 she was admitted for a suicide attempt with coumarin.

Her fifth admission to BCH was on October 5-10, 1967 for recurrent pulmonary emboli. The patient was discharged to her local physician.

Comment: This patient developed most of the

complications of paraplegia and several which may not be associated with it. She had severe thrombophlebitis, recurrent osteomyelitis, decubitus ulcers (which could not be completely controlled), and depressive reaction with a suicide attempt. In addition, she had what appeared to be a folic acid deficiency and peripheral vascular insufficiency of uncertain cause, resulting in a necessary amputation.

Summary: Patients with spinal cord injuries challenge nearly every aspect of medical care. In the acute stage they may require the intervention and exquisite coordination of a number of specialists working together as a team. Nursing care is always stretched to the limit in the prevention of decubitus ulcers.

During the stage of recovery, psychiatric problems may arise: Depression may set in at a time when the cooperation of the patient in self-care is essential.

Even if the acute and recovery hurdles have been passed successfully, the long-term problems of these patients increase and frequently result in multiple hospital admissions. Nowhere is the physician's long-term interest required more; nowhere is the patient's motivation and cooperation more important; in few situations are preventive measures more essential.

REFERENCE

1. Janda, W. E., et al: Fracture-dislocation of the cervical part of the spinal column in patients with ankylosing spondylitis. *Mayo Clin Proc* 43:714, 1968.

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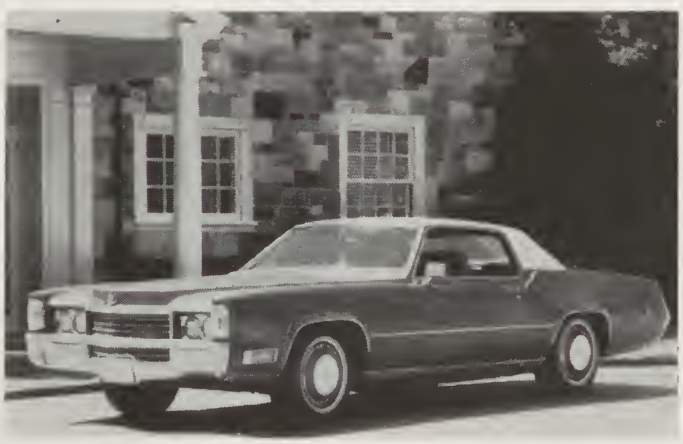
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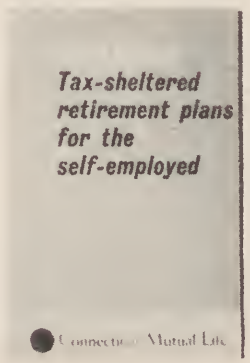


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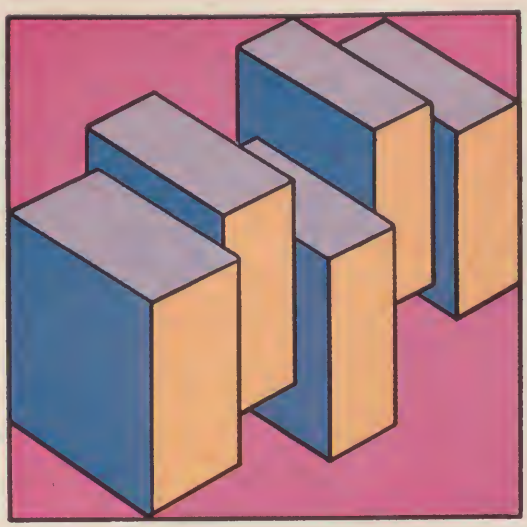
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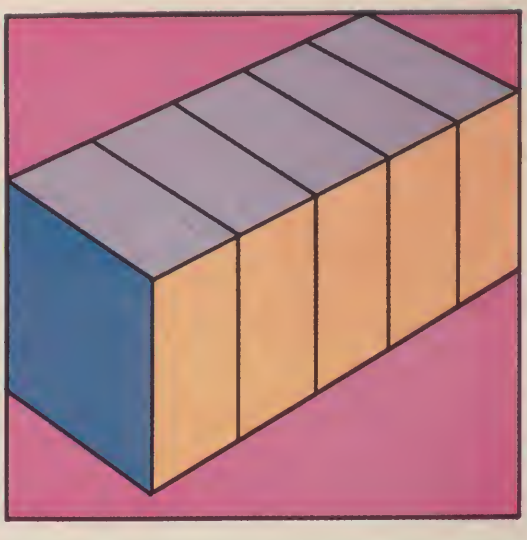
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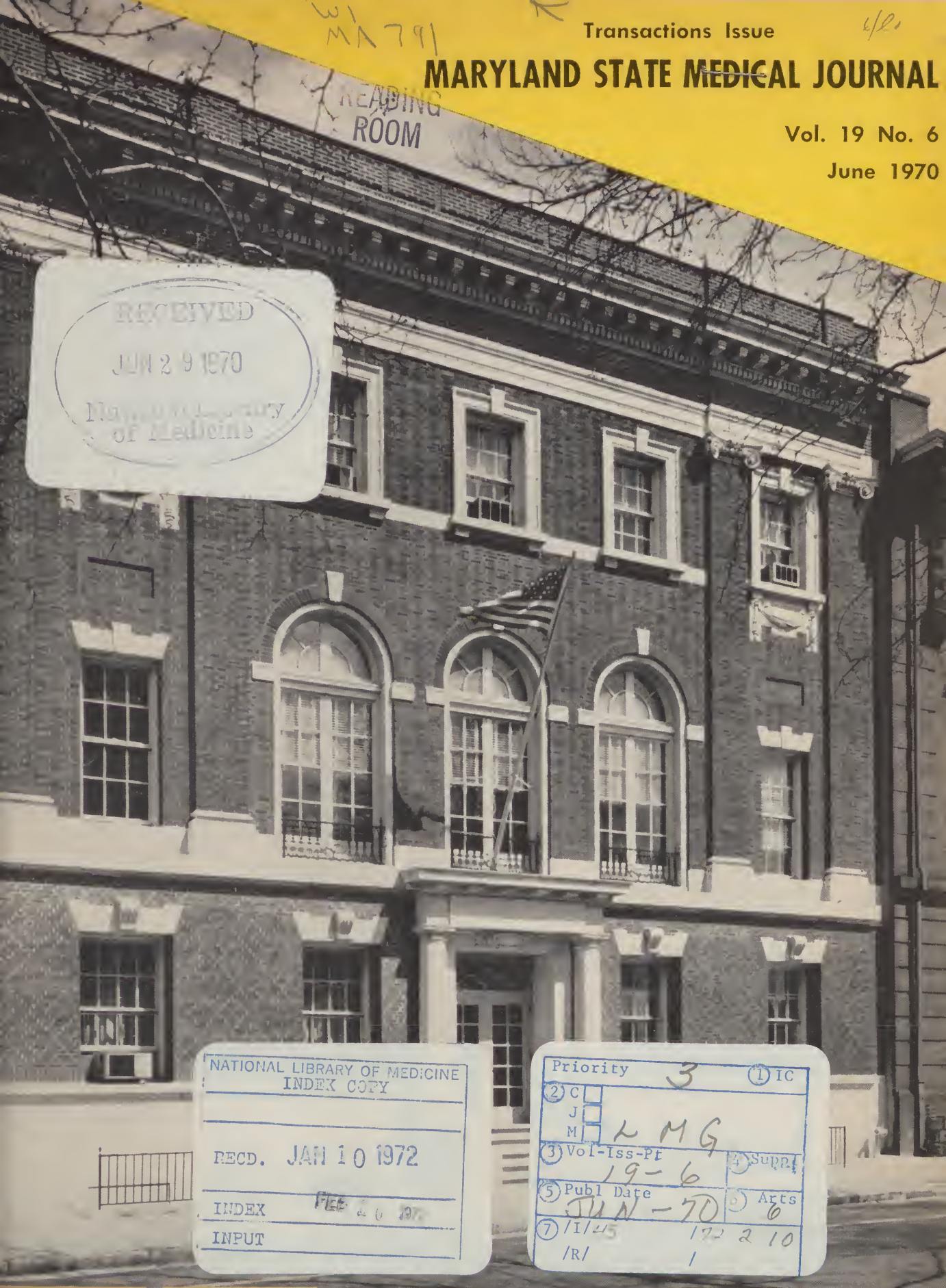
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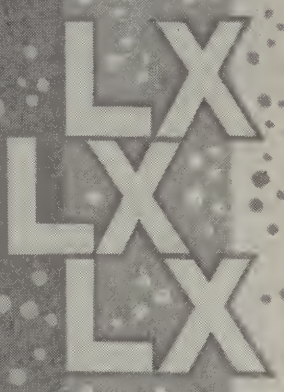
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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maryland state MEDICAL JOURNAL

VOLUME 19 JUNE 1970 NUMBER 6

CONTENTS:

Editorial—Reach to Recovery—A Program of the American Cancer Society, Edward A. Sawada, MD; Albert C. W. Montague, MD; Mrs. Sonia K. Lowitz 5

A Survey of Heritable Disorders in Maryland, Patrick F. Maloney, MD, MPH; Margaret H. Abbott, RN, MPH; Helen Abbey, ScD; Benjamin D. White, MD, MPH 43

"A rapid increase in research discoveries and an awareness of the value of genetic counseling have heightened interest in medical genetics. As a result of this trend, at least 15 state health departments have started programs in genetics. The present study was undertaken in collaboration with the Maryland State Department of Health as a preliminary step in expanding health services in genetics."

The Number of Children and the Supply of Physicians in Maryland Since 1940, Oscar C. Stine, MD, DrPH 51

"In January 1968 we found that present educational facilities and present patterns of recruitment or of practice would not satisfy the increasing demand for physicians to provide medical care for children in private offices.

"The Committee on Medical Care of the Maryland State Planning Commission had at that time received reports of shortages of physicians which are understood to be problems in distribution. To study patterns of distribution we reviewed population changes for each county in Maryland and compared them with the number of pediatricians and general practitioners in the same counties."

Annual Reports 56

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 102

Maryland State Department of Mental Hygiene—A Report to the Fifteen Southern States 107

Library Page—News and New Accessions 113

Tuberculosis—Advantages of Quantitative Cultures in Diagnosing and Treating Acute Bacterial Pneumonia 123

Alcoholism—The Johns Hopkins Alcoholism Unit: Half-Way House and In-Hospital Treatment, Shari Mayer 127

Rehabilitation Notes—Pressure Sores—Their Cause, Prevention, and Treatment, Alexander S. Dowling, MD 131

Heart Page—How 137

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NOTE: Delegates and Alternates please save this issue for the semiannual meeting September 10-12 in Hershey, Pa. No separate booklet containing annual reports will be published.

Doctors Take Note 6

Component Society News 8, 16, 105

Semiannual Meeting News 13, 125

Book Reviews 21

Minutes of the House of Delegates' Meetings in April 26

Medical News 31

The Month in Washington 34

Information for Authors 42

Annual Meeting Highlights 98

Executive Director's Newsletter 109

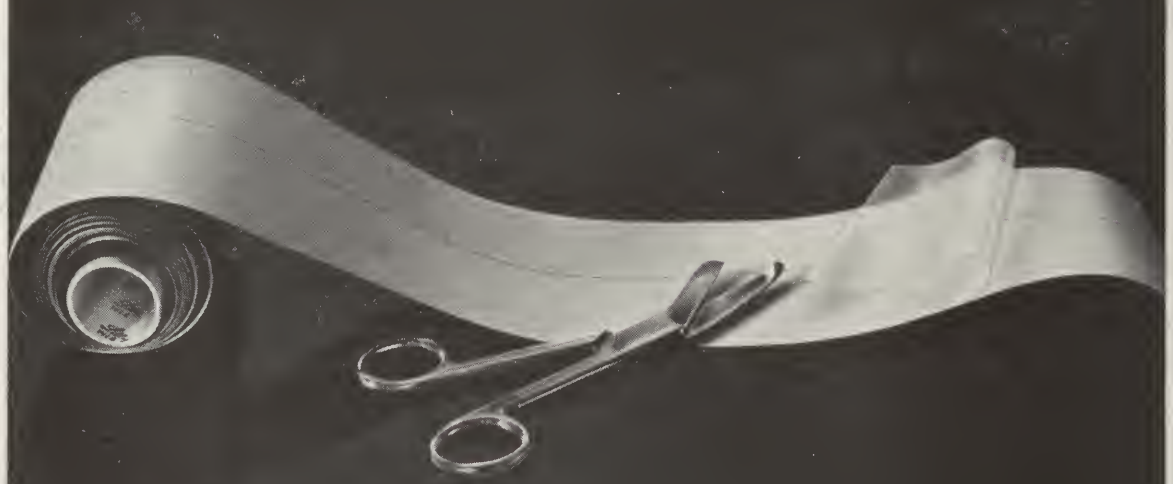
Woman's Auxiliary 117

Directory Coupon 142

Advertising Index 143

Classified Advertising 144

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Additional information ava

REACH TO RECOVERY

EDWARD A. SAWADA, MD
Chairman, Service Committee
American Cancer Society
Maryland Division, Inc.

ALBERT C. W. MONTAGUE, MD
Maryland State Medical Advisor
Reach to Recovery Program

MRS. SONIA K. LOWITZ
Maryland State Co-ordinator
Reach to Recovery Program

A Program of the American Cancer Society

The number of patients with mastectomies has increased faster than the available supply of surgeons, placing an added burden on physicians, nurses, and other hospital personnel. It is difficult for them to cope with all the time-consuming habilitative activities which are essential to the recovery of the mastectomy patient.

The *Reach to Recovery Program* of the American Cancer Society, Maryland Division, is designed to help the medical personnel meet this enormous need.

Reach to Recovery's main function is a woman-to-woman program, whose sole purpose is to provide physical, emotional, and cosmetic information and support to the hospitalized mastectomy patient. The patient is able to see and talk to another woman who has had similar surgery.

This free service is a segment of the Patient Service Program of the American Cancer Society. It is *not a club.*

Carefully screened and trained *Reach to Recovery* volunteers visit patients in the hospital three to six days following surgery for the purpose of giving general reassurance for more immediate comfort. The volunteers are taught strict medical ethics. They do not discuss the medical aspects of the operation. All medical questions are referred to the patient's surgeon. Volunteers may visit a patient only with the surgeon's permission and exercises are demonstrated only with the surgeon's permission.

When the volunteer visits, she gives the patient a kit which contains a manual, a ball and a length of rope for exercises, a temporary prosthesis made of washable dacron fluff, a letter to husbands and teenagers, as indicated, and a list of commercial establishments selling permanent prostheses.

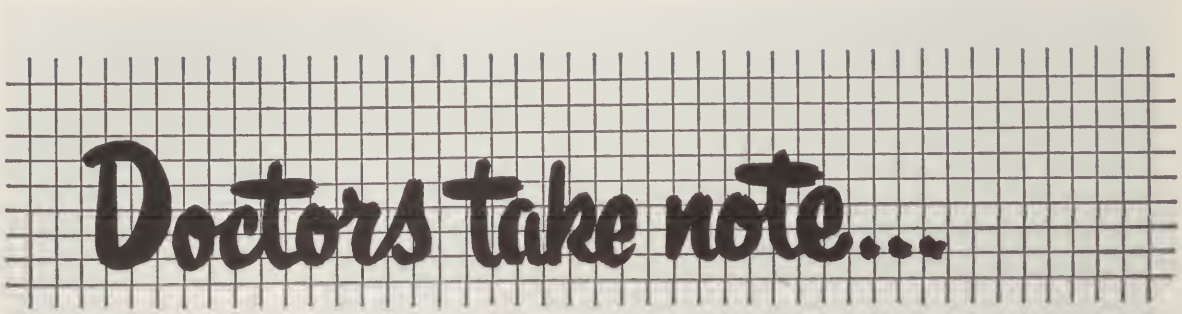
The goal of *Reach to Recovery* is to provide:

1. **Assistance for emotional stability at a time of crisis.**
2. **A mechanism for the patient to relate to another woman who has had the same surgery—living visual proof that it is possible for her to look normal and to resume her normal activities.**
3. **Free, specialized, practical help to the mastectomy patient without interfering with the physician-patient relationship.**

Another important aspect of *Reach to Recovery* is an educational plan for health professionals and personnel responsible for the comfort of the mastectomy patient. This is conducted in the form of lectures and demonstrations to nurses, students, and other hospital personnel.

Reach to Recovery has been enthusiastically accepted in many of the Baltimore metropolitan area hospitals and other hospitals throughout the state.

Further information about *Reach to Recovery* may be obtained by calling the local unit of the American Cancer Society.



JUNE 21, 1970
CONTINENTAL GYNECOLOGIC SOCIETY

22nd Annual Meeting: Colorado Springs, Colorado. Contact: New York Hospital, Cornell Medical Center, Department of Obstetrics and Gynecology, 525 East 68th Street, New York, New York 10021.

JUNE 22-26, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS/UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

Postgraduate Course—Perinatal Medicine: University of Colorado School of Medicine, Aspen, Colorado. Morning sessions will be devoted to reviews of broad topics and open discussion periods. Afternoon workshops will include current techniques in intensive care of the high risk pregnant patient and of the newborn infant, as well as animal research techniques in fetal physiology. Tuition: $125. Contact: The Department of Obstetrics and Gynecology, University of Colorado School of Medicine, 4200 East Ninth Avenue, Denver, Colo. 80220.

JUNE 22-JULY 3, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS/AMERICAN INSTITUTE OF FAMILY RELATIONS

Graduate Workshop—Education For Family Living: Pepperdine College, Los Angeles, Calif. Registrants will be assigned to interest groups of their choice. Contact: Mrs. Rose Blake, Registrar, 5287 Sunset Blvd., Los Angeles, Calif. 90027.

JUNE 25-27, 1970
AMERICAN SOCIETY FOR COLPOSCOPY AND COLPOMICROSCOPY/DEPARTMENT OF GYNECOLOGY AND OBSTETRICS, WOMEN'S MEDICAL COLLEGE OF PENNSYLVANIA

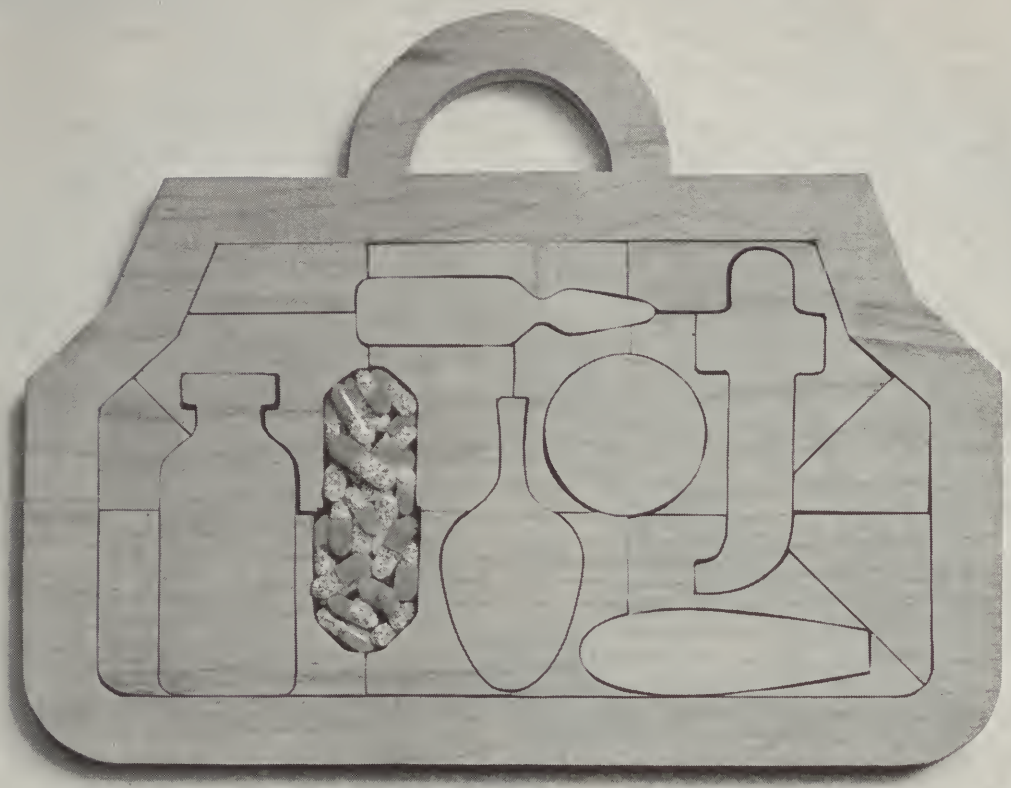
10th Basic Colposcopy Course: Philadelphia, Pennsylvania. Colposcopy, theoretical and practical with histopathologic correlation. Write: Joseph W. Scott, MD, Registrar for Colposcopy Courses, 701 DuPont Bldg., Miami, Florida.

JULY 14-18, 1970
SOCIETY FOR THE STUDY OF FERTILITY

Annual Conference: Liverpool, England. Contact: Mr. D. Casey, 141 Newmarket Road, Cambridge CB5 8HA, England.

JULY 17-18, 1970
COLORADO DIVISION, AMERICAN CANCER SOCIETY/COLORADO MEDICAL SOCIETY

24th Annual Rocky Mountain Cancer Conference: Brown Palace Hotel, Denver, Colorado. The guest faculty will discuss G. I. tract tumors and soft tissue cancers. Write: The Rocky Mountain Cancer Conference, 1764 Gilpin Street, Denver, Colo. 82018.



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Baltimore County Medical Association
April Meeting Notes

The regular monthly meeting of the association was held at the Sheppard Pratt Hospital on Wednesday, April 15, 1970. The Vice-President, John Krager, MD, presided. The new members were first introduced and given a warm welcome. The minutes of the previous meeting were approved as read. Herbert Levickas, MD, the Secretary-Treasurer, reported approximately $24,500.00 in the treasury. Dr. Levickas read a letter from Martin Middleton, MD, Chairman of the Legislative Committee of the Faculty, thanking the members for their aid in Annapolis.

Dr. Krager announced that there are 403 members in the Baltimore County Medical Association. The next meeting will be held at the Eudowood Plaza on May 22, 1970, starting at 6:30 PM with cocktails, followed by dinner at 7:30 PM. This will be a joint meeting with the Woman's Auxiliary. The June meeting will be at St. Agnes Hospital with Neil Solomon, MD, PhD, as the speaker.

A report of the House of Delegates meeting was read by Edward Krieg, MD, one of the delegates.

A motion was passed to donate $100 to the new Franklin Square Hospital.

Three new members were unanimously approved.

Dr. Krager introduced Robert Gibson, MD, Medical Director of the Sheppard Pratt Hospital, who gave an introductory talk concerning an emergency psychiatric service to be started at the Hospital on June 1. He then introduced Samuel Blumenfeld, MD, who will head this new program. Dr. Blumenfeld reported that a grant has been received from the State Department of Health for this emergency service. The patients will be seen by a medical resident at the Greater Baltimore Medical Center who would then contact a psychiatric resident at the Sheppard Pratt Hospital. One of the purposes of this "crisis intervention clinic" is to see patients as soon as possible and perhaps avoid an admission to a state mental hospital.

Dr. Krager thanked Dr. Gibson and Dr. Blumenfeld. There being no further business, the meeting was adjourned.

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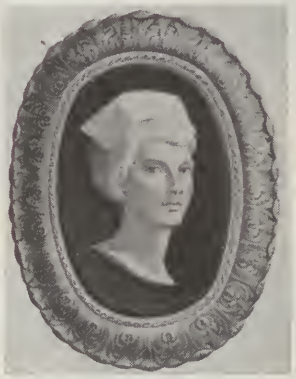
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Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction.

Side effects: The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction in dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

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og on the Embankment. Two figures emerge into silhouette against a aloed street lamp. The flare of a match reveals the profile of Sherlock olmes. As he lights his calabash, his companion speaks:

By Jove, Holmes, that amazing intuition of yours has proved right gain. What we're looking for is a single entity. I thought we were caling with several others—even twins. But now—I'd say we've ncovered a double agent."

Tell me more, Watson, and be quick about it!"

Watson withdraws a folded paper from inside his greatcoat, and ads aloud from it):

The key to the whole cypher is SYNTHROID (sodium levothy-xine)"...

Shhh! Watson, not so loud! You'll alert our quarry."

Watson continues): "A single entity that serves two functions."

A master stroke, Watson."

Follow along, Holmes. In the neighborhood of 95% of the circulat-g thyroid hormone is levothyroxine—T_4 as you call it. T_4 is bound thyroxine-binding proteins in the serum. It becomes available only adually to tissue cells—as free thyroxine."

"Is that why there's such a smooth, predictable response, Watson?"

"Quite! With agent T_4, SYNTHROID, the chances of a precipitous rise in metabolic rate are lessened."

"But how does 'free' thyroxine fit into the picture?"

"Well, Holmes, you might call it the tissue thyroid hormone—because 'free' thyroxine (that is, thyroxine not bound to protein) is active at the tissue level. It is gradually released from thyroxine-binding proteins. Each daily dose of SYNTHROID is mostly bound to thyroid-binding proteins, and slowly released as 'free' thyroxine—the form in which it is metabolically active."

"Magnificent, Watson! So protein-bound thyroxine is the major form of circulating thyroid hormone, and it is released as 'free' thyroxine. And that's why SYNTHROID is able to simulate the normal process so artfully. Q.E.D."

"Not so fast, Holmes. SYNTHROID works for the *physician*, too. Because its dosage is more precisely controllable, and because response is so smooth and predictable, the *doctor* gets fewer phone calls in the wee hours from agitated patients. Both parties get more sleep!"

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Frederick County Medical Society

Meeting Notes

Ernest A. Dettbarn, MD, Journal Representative

Reactivation of the county medical society scholarship fund; endorsement of the goals of the Frederick County Ambulance and Rescue Service with an urgent appeal to the county commissioners to give financial support to this service; and a vote of support FOR the proposed liberalization of the abortion laws by the society highlighted the actions taken at the March dinner-meeting of the Frederick County Medical Society.

Guest speaker for the evening's meeting, held this month at the Francis Scott Key Hotel, was Mr. Richard F. Crombie, Director of the Frederick County Planning and Zoning Commission. In reviewing the "Future of Frederick County", he made it quite clear that projected population increases would require increased public services, especially medical services. His predictions were based on the fact that between 1950-1960 there was a 15.5% increase in the county population, and as it stands now, there will probably be a 27% increase for the decade 1960-1970. Considering the increasing number of industries interested in Frederick County, with its outstanding desirability for living and working, and the fact that already there are plans for vast developments, Mr. Crombie urged that the county medical society conduct a careful survey of presently existing medical facilities as a basis for future planning.

The advice of the speaker was well received by the large number of members in attendance. Mr. Crombie was pleased to learn that the society had already established a Physician Procurement Committee led by George Smith, MD, and a committee to study the delivery of health services of the county headed by John Harvey, MD.

The society was informed by Robert Roberts, MD, of his committee's work with the directors of the Frederick County Ambulance and Rescue Service. He reported that only one unit in the county received any financial support from the county. Recognizing the increasing cost of operating the many volunteer services and the difficulty in raising sufficient funds by dinners, carnivals, etc., the society urged that funds be included in the next county budget to help support these volunteer units whose services were so valuable to the people of the county.

The society president, A. M. Powell, MD, called upon B. O. Thomas, Jr., MD, chairman of the medical scholarship committee, to present his committee's plans for reactivation of the scholarship fund. Dr. Thomas' committee recommended that a grant of $1,000 be made available each year for a Frederick County resident who needs financial help with his medical school expenses. The society would make this amount available from its funds and it would not have to be paid back provided the person receiving the grant would practice for at least two years in Frederick County. The society endorsed this proposal.

Charles Spicknall, MD, local health officer, informed the members of the increased number of cases of rubeola in a nearby community and the efforts his department was making to contain these cases, including a mass immunization program in the immediate area and surrounding areas for those who were not previously protected. The members present were also alerted to the side effects being seen in some youngsters who received the rubella vaccine. These included aches and pains in the arms and legs somewhat resembling the symptoms of rheumatic fever. These side effects, reported by Edward Koenigsburg, MD, were not serious or long-lasting, but until their cause had been determined, they were of some concern to some local physicians and parents.

President Powell expressed the feeling of mourning of the society on the passing of member emeritus, J. G. F. Smith, MD, of Brunswick. It was just last year that the Med-Chi had honored him with a plaque for 54 years of medical practice.

The remainder of the meeting was devoted to a discussion of the termination of pregnancy. The society passed a motion, with but one dissenting vote, in support of a liberalization of the abortion laws and instructed its president to send a telegram to the Governor expressing our support of the abortion bill before the legislature.

Schering

After only one year:

Administered to more people than live in Dundalk, Annapolis, and Bethesda.*



Injectable
Garamycin®
brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Dundalk, Annapolis, and Bethesda is 193,500. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Antibiotics*							
	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	99.5% 962	84.7% 992	86.2% 995	76.1% 67	32.7% 1,020	96.3% 640	82.9% 1,028	77.1% 1,026
Aerobacter aerogenes	95.9% 2,739	86.1% 2,818	53.5% 2,985	58.8% 1,514	22.7% 3,066	88.6% 2,603	85.8% 3,071	67.8% 2,981
Klebsiella aerobacter group	98.8% 566	83.9% 547	66.1% 522	60.5% 276	28.0% 553	89.5% 560	86.2% 587	62.8% 433
Klebsiella, all others	92.7% 2,944	83.3% 3,186	77.4% 2,976	67.5% 627	13.5% 2,883	95.0% 2,105	81.6% 3,212	70.6% 3,063
Pseudomonas aeruginosa	91.6% 4,528	29.8% 4,460	6.6% 4,418	6.6% 1,279	6.0% 4,360	91.3% 3,852	26.9% 4,608	26.4% 4,404
Proteus, indole-positive	91.8% 1,031	85.8% 1,062	39.9% 981	54.1% 364	40.2% 1,042	10.3% 758	76.1% 1,096	42.1% 1,051
Proteus mirabilis, indole-negative	94.9% 3,272	90.1% 3,378	83.1% 3,290	77.5% 975	78.0% 3,274	8.8% 2,634	85.9% 3,469	26.8% 3,278
Proteus, unspecified	96.2% 1,335	85.8% 1,371	71.7% 1,434	70.0% 647	64.7% 1,435	11.2% 1,233	76.0% 1,421	22.4% 1,298
Escherichia coli and all other *Escherichias*	96.4% 12,557	91.4% 12,818	87.8% 12,686	88.8% 4,251	74.6% 12,899	95.4% 10,623	94.1% 13,086	70.0% 12,559
Paracolobactrum, all	93.4% 303	88.9% 325	62.0% 305	74.2% 62	43.8% 340	80.9% 215	87.1% 350	72.6% 340
Coliform bacteria	99.0% 593	91.2% 649	81.5% 637	66.7% 21	52.7% 624	95.6% 607	91.6% 678	76.1% 637
Totals	95.1% 30,830	80.5% 31,606	65.3% 31,229	68.1% 10,083	50.3% 31,496	75.8% 25,829	79.7% 32,606	56.5% 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus*, coagulase-positive	97.4% 1,548	88.8% 1,458	97.7% 2,050	98.7% 636	61.1% 1,559	20.4% 628	94.4% 2,123	83.7% 1,966
Staph—*S. aureus*, unspecified	99.3% 993	92.8% 902	98.1% 1,289	95.3% 213	45.8% 1,153	29.3% 116	96.4% 1,427	82.3% 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August,1969).[8]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®

brand of gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	Resistant/ Moderately Severe	Serious/Life-Threatening
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those wit pre-existing renal damage, treated with GARAMYCIN Injectabl usually for longer periods or with higher doses than recommende

GARAMYCIN Injectable is potentially nephrotoxic, and thi should be kept in mind when it is used in patients with pre-existin renal impairment. Kidney function diminished by infection of th upper urinary tract may, however, improve during effective trea ment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such a streptomycin and kanamycin or of potentially nephrotoxic dru such as polymyxin, colistin, and kanamycin with gentamicin sulfat has not been shown to afford any clinical advantages and, moreov may result in additive toxicity. Monitoring of vestibular, cochlea and renal function will provide guidance for therapy in such case

Precautions: In patients with impaired renal function in whor serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these pa tients or in those in whom recommended dosage or duration o therapy must be exceeded as a life-saving measure, routine studi of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory fun tion and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not r sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectab may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant an mals have not revealed teratogenic or ototoxic effects in the fetu GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisab by the physician.

Adverse Reactions: The overall incidence of ototoxicity considere related to treatment with GARAMYCIN Injectable was 2.8 per ce (16 of 565 patients). Contributory factors (two or more factors we relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently r ceived other potentially ototoxic antibiotics (streptomycin or kan mycin), and 5 were over 60 years of age. Six also had decreas high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients show increases in BUN that were probably related to treatment wi GARAMYCIN Injectable. Of 20 increases probably or possibly relat to treatment, 7 were reversible, 9 occurred in terminal patients, a 4 had no follow-up.

Other adverse reactions associated with treatment were one instar each of urticaria, decreased hematocrit, and reversible depressi of granulocytes with normal bone marrow. Other rarely report and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotensi convulsions, twitching, salivation, nausea, vomiting, increased tra aminase activity (SGOT or SGPT), increased serum bilirubin, creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-d vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin gram-negative urinary and pulmonary infections, Arch. Int. M *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., a Smith, J. K.: Gentamicin in the treatment of pulmonary infectio J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a n aminoglycoside antibiotic: Clinical and laboratory studies in urin tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clini experience with gentamicin, data from 12 German clinics, in G tamicin: First International Symposium, Paris, January 19 Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Labo tory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationw hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachus (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommen in Package Insert.

For more complete prescribing details, consult package insert Physicians' Desk Reference. Schering literature is also availa from your Schering Representative or Medical Services Departm Schering Corporation, Union, New Jersey 07083.

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Book Reviews

DRUGS OF CHOICE, 1970-71, Walter Modell, MD, ed.; The C. V. Mosby Company, St. Louis, Missouri, 1969.

Many well-known authorities have contributed to this book, which helps the physician to select the best drug for a specific therapeutic problem. It combines knowledge from all the various specialities which, if published previously, has been published separately. The opinions of experts provide the physician with a comprehensive source of clear, concise, authoritative, and practical answers when faced at a critical moment with choosing the right drug.

It is a well-documented publication, adequately indexed and cross-referenced for quick and easy use.

EMPHYSEMA, A Doctor's Advice for Patients and Their Families, Fred A. Obley, MD; Beacon Press, Boston, Massachusetts, 1970.

This book is written in the language that a physician would use in explaining this chronic respiratory disease to his patient. It contains practical, detailed information and helpful exercises for the patient to be used in full cooperation with his physician.

Anyone who smokes or who coughs chronically should read this book. The diagnosed emphysemic should read it a second time and keep it on his shelf for ready reference.

DISEASES OF BONE AND JOINTS, Louis Lichenstein, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This book serves as a companion volume to *Bone Tumors* by the same author. It deals with skeletal disease in general, apart from neoplasms, and provides a concise yet informative comprehensive survey for basic orientation. As such, it meets the needs of orthopedists, general surgeons, radiologists, pathologists, pediatricians, internists and almost any physician, whatever his specialty.

It is a volume that should at least be skimmed by any physician who wishes to keep up to date in his knowledge in this area.

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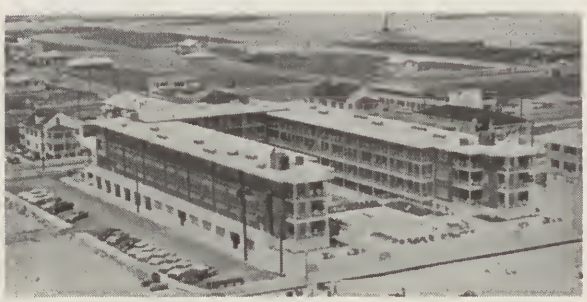
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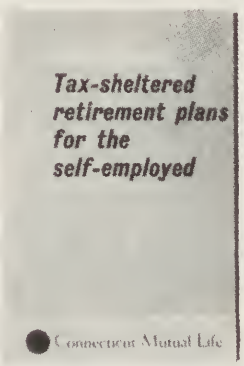


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MINUTES

First Meeting, 172nd Annual Session, House of Delegates
(268th Meeting)
Medical and Chirurgical Faculty of the State of Maryland
Wednesday, April 1, 1970
The Alcazar, Baltimore, Maryland

The 268th meeting, first of the 172nd Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:40 AM, Wednesday, April 1, 1970, at The Alcazar, Baltimore, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors: Robert T. Adkins, Wicomico County; Manning W. Alden, Council; Robert G. Angle, Montgomery County; Charles Bagley, III, Wicomico County; Timothy D. Baker, Baltimore city; John G. Ball, Council; James W. Banks, Washington County; George S. Banning, Prince George's County; Richard D. Bauer, Past President; Wilbur N. Baumann, Dorchester County; Emidio A. Bianco, Baltimore city; * Norman K. Bohrer, Prince George's County; Francis J. Borges, Baltimore city; * Katherine H. Borkovich, Baltimore city; M. McKendree Boyer, Past President; Douglas G. Carroll, Baltimore city; Katharine A. Chapman, Montgomery County; John T. Chissell, Council; John N. Classen, Baltimore city; Archie R. Cohen, Washington County; * Joseph R. Cowen, Baltimore city; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore city; H. Vincent Davis, Cecil County; John B. De Hoff, Baltimore city; DeWitt E. DeLawter, Montgomery County; J. Sheldon Eastland, Past President; William Carl Ebeling, Council; Wolcott L. Etienne, Council; George G. Finney, Jr., Baltimore city; Vincent J. Fiocco, Carroll County; Whitmer B. Firor, Past President; * Ronald H. Fishbein, Baltimore city; Elliott R. Fishel, Baltimore city; Russell S. Fisher, President; * Abraham Genecin, Baltimore city; Robert B. Goldstein, Baltimore city; E. Gordon Grau, Baltimore County; George H. Greenstein, Baltimore city; Paul F. Guerin, Council; William B. Hagan, Council; John C. Harvey, Council; William G. Helfrich, Baltimore city; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; * Edward O. Hunt. Jr., Baltimore city; Ferd E. Kadan, Baltimore city; Arthur T. Keefe, Jr., Council; Robert C. Kimberly, Council; Seruch T. Kimble, Council; Edward L. J. Krieg, Baltimore County; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Charles H. Ligon, Montgomery County; Elmer G. Linhardt, Board of Medical Examiners; Deonis M. Lupo, Baltimore city; Charles B. Marek, Baltimore city; Francis C. Mayle, Jr., Montgomery County; Wm. E. McGrath, Baltimore County; Karl F. Mech, Council; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore city; Andrew C. Mitchell, Wicomico County; Marvin I. Mones, Council; Samuel Morrison, Council; C. Herbert Mueller, Jr., Baltimore County; * Neil Novin, Baltimore city; Charles F. O'Donnell, Past President; * Malcolm D. Phillips, Harford County; William A. Pillsbury, Jr., Council; Thaddeus E. Prout, Baltimore city; * Belden R. Reap, Montgomery County; J. Morris Reese, Past President; William F. Renner, Baltimore city; Donald J. Roop, Council; Harry Paul Ross, Kent County; John F. Schaefer, Council; * Marvin M. Schuster, Baltimore city; Margaret L. Sherrard, Baltimore County; Arthur G. Siwinski, Past President; R. Kennedy Skipton, Prince George's County; Gordon M. Smith, Montgomery County; Roland T. Smoot, Baltimore city; Aaron C. Sollod, Baltimore city; William G. Speed, III, Council; George R. Spence, Montgomery County; Robert J. Thomas, Council; Chris P. Tountas, Baltimore city; Francis J. Townsend, Jr., Worcester County; John B. Umhau, Montgomery County; Thomas E. Van Metre, Jr., Baltimore city; * Baltasar B. Velez, Baltimore County; Emerson C. Walden, Baltimore city; Hugh W. Ward, Calvert County; J. Arthur Weinberg, Council; Lawrence R. Wharton, Jr., Baltimore city; Charles E. Wright, Frederick County; * N. Louise Young, Baltimore city; Raymond M. Yow, Council. Present also were staff members.

INVOCATION

Karl F. Mech, MD, delivered the invocation.

ANNOUNCEMENTS

The President made certain announcements with regard to the conduct of business at the session.

MINUTES

The minutes of the House of Delegates Semi-annual Session, Hershey, Pa., on September 5, 1969; and the Special Session, held at Baltimore, Md., on December 13, 1969, having been distributed to members and having been approved by the Executive Committee, were presented to the House for information.

INTRODUCTION OF GUESTS

Maynard P. Pride, MD, president of the West Virginia Medical Association; and William A. Barrett, MD, president of the Pennsylvania Medical Society, were introduced to the House and spoke briefly.

NECROLOGY

After the Secretary read the following names of deceased members, the members of the House of Delegates rose in observance of a moment's silence in respect for their deceased colleagues:

Allegany County

Moulton, George Allen, Jr.	December 7, 1969
Walters, Alvin J.	June 19, 1969
Williams, William F.	October 23, 1969

Anne Arundel County

Gaalaas, A. F.	May 25, 1969
Sheehan, Joseph C.	March 23, 1969
Waite, Merton T.	July 29, 1969

Baltimore city

Bernstein, Alan	February 24, 1969
Bodenheimer, Ernst	April 7, 1969
Bogorad, Daniel E.	March 21, 1969
Chalfant, Archibald S.	September 27, 1969
Demarco, Salvatore J., Jr.	April 11, 1969
Ellis, Francis A.	December 6, 1969
Feinglos, Israel J.	September 14, 1969
Finney, John M. T., Jr.	April 15, 1969
Freedom, Leon	July 19, 1969
Johnson, Robert W., Jr.	August 24, 1969
Keller, Charles J.	October 11, 1969
Lerner, Philip F.	January 23, 1970
Levy, Charles S.	February 24, 1970
Levy, Kurt	August 28, 1969
Lippy, George D.	January 17, 1970

Macgowan, Birkhead	December 1, 1969
Marr, Ernest G.	January 12, 1970
Miller, Isaac	February 4, 1970
Myers, J. Carl	July 12, 1969
O'Rourk, Thomas R., Sr.	July 24, 1969
Park, Edward A.	July 12, 1969
Polvogt, Leroy M.	January 23, 1970
Seidel, Herman	September 2, 1969
Sullivan, Maurice	October 28, 1969
Todd, Homer U.	March 1, 1969
Ullman, Alfred	January 9, 1969
Weinberg, Tobias	November 21, 1969
Weinberger, Richard	December 6, 1969

Baltimore County

Everett, John Thomas	July 27, 1969
Hetherington, Leon H.	February 9, 1969

Caroline County

Anderson, F. M.	December 9, 1969

Carroll County

Woodward, Lewis K.	November 16, 1969

Frederick County

Lea, Melvin E.	January 24, 1970
Smith, J. G. F.	March 13, 1970
Thomas, Bernard O., Sr.	April 15, 1969

Harford County

Palmer, Gerald C.	March 8, 1970

Howard County

Burgtorf, George E., Jr.	July 31, 1969

Kent County

Eglitis, Rudolfs	February 2, 1969

Montgomery County

DeMayo, John L.	August 31, 1969
Huff, Wheeler O.	November 29, 1969
Masur, Jack	March 8, 1969
Richardson, Francis X.	January 20, 1970
Vann, H. King	June 12, 1969

Prince George's County

Mulligan, John J.	March 31, 1969
Vasconcellos, John B.	March 30, 1969

Talbot County

Fazekas, Joseph F.	
Palmer, M. Virginia	November 11, 1969
Schneider, John F.	February 24, 1969

Washington County

Keadle, Robert F.	December 1, 1969

Wicomico County

Waters, Zack J.	July 13, 1969

Affiliates

Elder, John D., Jr.	July 30, 1969
Weber, Konstantin	December 24, 1968

SPECIAL RECOGNITION OF DECEASED MEMBERS

John F. Schaefer, MD, Council Chairman, offered the following resolution in memory of a distinguished member who had died during the previous year, which was adopted unanimously:

ROBERT W. JOHNSON, JR., MD, 1891-1969

Whereas, Robert W. Johnson, Jr., MD, died on August 24, 1969; and

Whereas, As the initiator of many progressive reforms in the area of biomedical research, he gave courage and support to developing competent physician-scientists before their creative abilities were hindered by academic responsibilities; and

Whereas, His foresight enabled institutions to recognize and direct their efforts toward postdoctoral training programs; and

Whereas, As an interested member of more than fifty years of the Medical and Chirurgical Faculty and the Baltimore City Medical Society, and an avid supporter of their activities; and

Whereas, As the father of two distinguished Maryland physicians; and

Whereas, His generosity, gentleness, and forthrightness in dealing with the challenges presented to him during his lifetime were truly exemplary qualities; and

Whereas, His distinguished record of accomplishments and his devotion to the profession endeared him to all, be it therefore

Resolved, That a copy of this resolution be sent to the relatives of Robert W. Johnson, Jr., MD, with the notation that this recognition of his efforts on behalf of the Faculty are in this small way hereby acknowledged.

HONORARY MEMBERSHIP

John F. Schaefer, MD, escorted W. B. Kouwenhoven, Dr.Ingr., MD (Hon.) to the podium and read the following certificate of Honorary Membership in the Faculty:

FOR HIS OUTSTANDING CONTRIBUTIONS TO THE PRACTICE OF MEDICINE AND THE GENERAL WELL-BEING OF HUMANITY

PRESENTATION OF FIFTY-YEAR PINS

The President awarded Fifty-year pins to the following members who were present for the meeting:

Baltimore City:	Leslie N. Gay, MD Louis F. Krumrein, MD F. Fred Ruzicka, MD Austin H. Wood, MD
Allegany County:	Howard L. Tolson, MD

Other physicians completing fifty years of Faculty membership but who could not be present were:

Baltimore City:	Zachariah R. Morgan, MD John G. Murray, MD
Baltimore County:	Lee K. Fargo, MD
Carroll County:	Charles L. Billingslea, MD

EMERITUS MEMBERSHIP

On motion of the Chairman of the Council, Dr. Schaefer, the following members who had received the recommendation of their respective societies and the Council, were elected to Emeritus Membership in the Faculty:

Baltimore City Medical Society:
Melvin H. Crocker, MD
Walter E. Fleischer, MD
Ralph S. Penner, MD
Alexander J. Schaffer, MD
Joseph Sindler, MD
Harry B. Smith, MD
William S. Stone, MD

Baltimore County Medical Association:
William E. Martin, MD, Harrisonville
William H. F. Warthen, MD, Baltimore

Carroll County Medical Society:
Charles L. Billingslea, MD, Westminster

Montgomery County Medical Society:
Paul N. Fleming, MD, Silver Spring
Paul V. Starr, MD, Takoma Park

COMMENTS OF THE PRESIDENT

Dr. Fisher, as President, then made extemporaneous remarks on various problems facing the profession today, involving Medicare and Medicaid matters; the importance of Peer Review activities; and the professional liability insurance problem.

ACTION DEFERRED ON RESOLUTIONS

Action was postponed by unanimous consent until the Friday meeting on the following two resolutions referred to the House of Delegates by the Council, which had received them from the Prince George's County Medical Society:

Part I That the Faculty be requested to work for legislative changes through the General Assembly of the State of Maryland by virtue of which the defendant in torts would be permitted to have the final option as to whether he would be tried before a Judge or a Jury

Part II That the Faculty be requested to work for legislative changes through the General Assembly of the State of Maryland seeking to have the *contingent* fee method of payment between attorney and client made illegal.

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

George G. Finney, Jr., MD, Chairman of the Maryland Medical Political Action Committee, spoke briefly on the activities of that group during the past year. *(For a complete report of this committee's activities see page 67.)*

TREASURER'S REPORT AND 1970 BUDGET

Karl F. Mech, MD, Treasurer, presented the 1970 budget for the information of the House, this having been adopted by the Council. The Treasurer advised that the Faculty's finances had been audited and that the printed audit would be available for the Semiannual session. *(See pages 81-95)*

MEDIC NETWORK 1970/71

Fred Heldrich, MD, subcommittee chairman, presented the following motion, which after amendment was adopted as follows:

> That the MEDIC Network be continued and that such funds to the extent of $16,000 be appropriated to finance the operation of the system for a one-year period, in order to produce stability and enable proper planning of programs of desired quality.

An additional motion was offered and adopted as follows:

> That a formal evaluation of the MEDIC program be made available when this item is up for consideration again.

BYLAWS COMMITTEE REPORT

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of certain Bylaw amendments which, after debate, were adopted in each case by more than the required two-thirds vote. *(See pages 58-62 for the complete report.)*

MEDICOLEGAL CODE OF COOPERATION AMENDMENT

Belden R. Reap, MD, on behalf of the Medicolegal Committee offered the following amendment to the Medicolegal Code of Cooperation, which was adopted:

> "Upon engaging a physician for consultation, evaluation and/or testimony, the attorney should make it clear whether the patient or the attorney will be responsible for payment of the fee."

The addition will be made to the paragraph entitled "Payment for Medical Services Rendered."

MEDIATION COMMITTEE REPORT DEFERRED

Action on the Mediation Committee Report was postponed by general consent to the Friday House of Delegates meeting.

NOMINATING COMMITTEE REPORT

Arthur G. Siwinski, MD, Nominating Committee Chairman, presented the committee's slate. *(See page 73 for details.)*

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent, the election to be held at the second meeting of the session, Friday, April 3, 1970, at the Faculty Building. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, Noon, April 2, 1970, at The Alcazar.

The Chair announced that technical problems prevented the printing of the Annual Reports in sufficient time for consideration at the Annual Meeting. These will be made available at the Semiannual Session. *(See pages 56-97 for Annual Reports.)*

LEGISLATIVE COMMITTEE REPORT

B. Martin Middleton, MD, was asked to speak briefly on the recently adjourned legislative session. He mentioned various bills adopted or rejected by the General Assembly.

The House of Delegates gave a rising vote of thanks to Dr. Middleton for his efforts in this regard.

There being no further business, at Noon the President made certain announcements and declared the House adjourned until 2:00 PM Friday, April 3, 1970 at the Faculty building.

WILLIAM A. PILLSBURY, MD, *Secretary*

Second Meeting, 172nd Annual Session, House of Delegates
(269th Meeting)
Medical and Chirurgical Faculty of the State of Maryland
Friday, April 3, 1970
Faculty Building, Baltimore, Maryland

The 269th meeting, second of the 172nd Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was held at the Faculty Building, 1211 Cathedral St., Baltimore, Maryland, at 2:00 PM on Friday, April 3, 1970, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors:

Robert T. Adkins, Wicomico County; Manning W. Alden, Council; Robert G. Angle, Montgomery County; Charles Bagley, III, Wicomico County; John G. Ball, Council; George S. Banning, Prince George's County; Richard D. Bauer, Past President; Wilbur N. Baumann, Dorchester County; Emidio A. Bianco, Baltimore city; Francis J. Borges, Baltimore city; *Katherine H. Borkovich, Baltimore city; Samuel Borssuck, Anne Arundel County; M. McKendree Boyer, Past President; Henry A. Briele, Council; Douglas G. Carroll, Baltimore city; John N. Classen, Baltimore city; Archie R. Cohen, Washington County; *Joseph R. Cowen, Baltimore city; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore city; John B. De Hoff, Baltimore city; DeWitt E. DeLawter, Montgomery County; J. Sheldon Eastland, Past President; *John F. Eyring, Baltimore city; George G. Finney, Jr., Baltimore city; Vincent J. Fiocco, Carroll County; Elliott R. Fishel, Baltimore city; Russell S. Fisher, President; Gina M. Glick, Allegany County; Marvin Goldstein, Baltimore city; Robert B. Goldstein, Baltimore city; George H. Greenstein, Baltimore city; William B. Hagan, Council; John C. Harvey, Council; William G. Helfrich, Baltimore city; Philip W. Heuman, Harford County; *A. Clark Holmes, Prince George's County; Ferd E. Kadan, Baltimore city; William H. Kammer, Jr., Baltimore city; Seruch T. Kimble, Council; Edward L. J. Krieg, Baltimore County; Herbert H. Leighton, Garrett County; Charles H. Ligon, Montgomery County; Elmer G. Linhardt, Board of Medical Examiners; Francis C. Mayle, Jr., Montgomery County; Wm. E. McGrath, Baltimore County; Karl F. Mech, Council; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore city; Andrew C. Mitchell, Wicomico County; Marvin I. Mones, Council; Samuel Morrison, Council; Charles F. O'Donnell, Past President; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Jr., Council; *Richard H. Pollen, Montgomery County; Thaddeus E. Prout, Baltimore city; J. Morris Reese, Past President; Guy M. Reeser, Jr., Council; William F. Renner, Baltimore city; Donald J. Roop, Council; Harry Paul Ross, Kent County; Peter Santucci, Montgomery County; John F. Schaefer, Council; Margaret L. Sherrard, Baltimore County; Arthur G. Siwinski, Past President; R. Kennedy Skipton, Prince George's County; Gordon M. Smith, Montgomery County; Roland T. Smoot, Baltimore city; Aaron C. Sollod, Baltimore city; George R. Spence, Montgomery County; Francis J. Townsend, Jr., Worcester County; John B. Umhau, Montgomery County; Thomas E. Van Metre, Jr., Baltimore city; *Baltasar B. Velez, Baltimore County; Philip F. Wagley, Baltimore city; Hugh W. Ward, Calvert County; Wm. C. Weintraub, Prince George's County; Lawrence R. Wharton, Jr., Baltimore city; John G. Wiswell, Baltimore city; Raymond M. Yow, Council. Staff personnel were also present.

ELECTION OF OFFICERS

There being no candidates from the floor and there being only one candidate for each of the positions to be filled, by unanimous consent the ballot was dispensed with. The entire Nominating Committee's slate was then elected by voice vote.

ADDITIONAL ELECTION

Arthur G. Siwinski, MD, Nominating Committee Chairman, offered the name of Emmanuel A. Schimunek, MD, to fill the post of first vice-president, effective with the conclusion of the Annual Meeting, 1970, through the Annual Meeting, 1971. The vacancy in this post was created by the election of John F. Schaefer, MD, as President-elect.

There being no other nominations from the floor, the President declared the election of Dr. Schimunek unanimous.

BOARD OF MEDICAL EXAMINERS ELECTION

The President advised the House that members of the Board of Medical Examiners had been elected in a General Session held on Thursday, April 2, 1970, as follows:

William G. Stewart, MD, Westminster
Elmer G. Linhardt,, MD, Annapolis

COMMISSION ON MEDICAL DISCIPLINE

The President advised the House that the Chairman of the Commission on Medical Discipline had asked him to make a brief report to the House, regarding activities of the Commission to date.

PRINCE GEORGE'S COUNTY RESOLUTIONS

The President asked for a vote on consideration of the following motion received from the Prince George's County Medical Society too late to be considered by the Reference Committee. Lacking a two thirds vote for consideration of these motions, they were dismissed.

Part I That the Faculty be requested to work for legislative changes through the General Assembly of the State of Maryland by virtue of which the defendant in torts would be permitted to have the final option as to whether he would be tried before a Judge or a Jury.

Part II That the Faculty be requested to work for legislative changes through the General Assembly of the State of Maryland seeking to have the *contingent* fee method of payment between attorney and client made illegal.

MEDIATION COMMITTEE REPORTS

Louis J. Kolodner, MD, on behalf of the Mediation Committee, moved to rescind the action of the House of Delegates taken in 1962 which read as follows, and which was adopted after debate:

> "Podiatrists should not be on hospital staffs nor engaged in open surgery."

Dr. Kolodner, on behalf of the Mediation Committee, moved to adopt the following motion, which after debate and amendment, was adopted as follows:

That the Faculty adopt the same standards as

of January 1, 1970 with respect to Podiatrists as the Joint Commission on Accreditation of Hospitals.

STAFF RECOGNITION

Anna Wynde Leake, who attained forty years of service in the Faculty employ in 1969, was honored with the presentation of a gold chain and locket.

WOMAN'S AUXILIARY PRESIDENT

Mrs. Wallace H. Sadowsky, president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, requested permission of the House to speak. There being no objection, permission was granted.

Mrs. Sadowsky then read a report of Auxiliary activities during the past year.

REFERENCE COMMITTEE REPORT

Herbert H. Leighton, MD, on behalf of the Reference Committee, recommended that Resolution 1A/70 be adopted. The House adopted this Resolution.

Dr. Leighton, on behalf of the Reference Committee, moved adoption of Resolution 2A/70. The House adopted Resolution 2A/70.

Dr. Leighton, on behalf of the Reference Committee, moved adoption of Resolution 3A/70. The House adopted Resolution 3A/70. *(See Annual Reports pages 79-80 for Resolutions 1A/70, 2A/70, and 3A/70.)*

FUTURE POLICY ON PODIATRY

B. Martin Middleton, MD, Legislative Chairman, offered the following motion which was adopted after debate:

> That the House urges the Legislative Committee to use every effort to attempt to retain the present legal limits of Podiatric practices.

MEDIC PROGRAMS

Robert T. Adkins, MD, of Wicomico County, moved

> That the President of the Faculty appoint an Ad Hoc Committee to investigate all facets of the MEDIC network and render a report to the House of Delegates at the 1970 Semiannual Meeting, with such report being distributed to all House members in advance of such meeting.

This motion was adopted, after debate.

MEDICARE LIMITATIONS

Donald W. Mintzer, MD, Baltimore city, brought to the attention of the House that a recent communication from Blue Shield places a limitation on the number of house calls, nursing home visits, etc., that a physician can make for a Medicare patient and moved for adoption of the following motion which, after discussion, was referred to the Council:

> That the Faculty direct its members on the Blue Shield Board to work towards elimination of arbitrary restrictions on the number of visits a physician may make in treating his patients.

PROGRAM COMMITTEE INSTRUCTIONS

The House, by a two thirds vote, agreed to consider the following motion which, on consideration, the House adopted as follows:

> Whereas, The Program and Arrangements Committee of the Faculty works long and hard to obtain speakers of national prominence for Annual and Semiannual meetings, both current and past; and
>
> Whereas, The attendance at some of the meetings of the current Annual Session was embarrassingly small, and
>
> Whereas, The quality of the various endowed lectureships is endangered; and
>
> Whereas, The Alcazar's future is somewhat in doubt and its facilities are not what could be considered the most modern and attractive; therefore, be it
>
> *Resolved,* That the Program and Arrangements Committee be instructed by the House of Delegates to:
>
> (1) Explore the possibility of finding a more attractive facility for the location of the Annual Meetings, and
>
> (2) Explore any necessary methods to increase physical attendance of members and guests commensurate with the quality of the speakers.

RATIFY COUNCIL ACTION ON REPEAL OF ABORTION LAWS

Dr. Schaefer, on behalf of the Council, offered the following motion which was adopted after amendment by more than a two thirds vote:

> That the action of the Council be ratified in supporting repeal of all abortion laws in the State of Maryland and that the Faculty be represented at the public hearing in this regard scheduled by the Governor for *Wednesday, April 22, 1970, at 2:00 PM.

ANNOUNCEMENTS AND NEW PRESIDENT

The Chair then made certain announcements, following which the new President was introduced to the House.

The President, by general consent, declared the House adjourned SINE DIE at 3:30 PM.

** later changed to Thursday, April 23, 1970, at 9:00 AM.*

WILLIAM A. PILLSBURY, MD, *Secretary*



MEDICAL NEWS

Simeon B. Alvaran, MD, and **Karim F. Rashad, MD,** of Baltimore, and **John Cordozo Payne, MD,** of Seat Pleasant, members of the American Society of Anesthesiologists, were recently named Fellows of the College.

* * *

The newly elected chairman of the Maryland State School Health Council is **John M. Krager, MD,** a pediatrician and assistant health officer in the Baltimore County Health Department. Dr. Krager will serve a three-year term.

Other officers elected to the Council, an advisory group to the state departments of education and health, include Oscar Jensen, vice-chairman, an associate in higher education with the Maryland State Teachers Association; and Miss Joan M. Wolle, secretary, chief of the Division of Health Education with the State Department of Health and Mental Hygiene.

* * *

One in every 16 persons in Maryland has now completed the **Medical Self-Help Training** program, according to O. Eugene Trivits, chief of the Division of Emergency Health Services of the Maryland State Department of Health. In 1969, 56,468 Marylanders completed the program, bringing to 212,733 the total number of graduates since the program began in 1963.

Medical Self-Help is a program designed to provide information and training that will help prepare people for survival in time of a natural or national crisis when the services of a physician or other trained personnel are not available. The course covers techniques of artificial respiration, treatment of shock, and healthful living under emergency environmental conditions.

* * *

An Information Center for Handicapped Children, funded by the U. S. Office of Education, **Bureau of Education for the** handicapped, has opened in Washington, D. C. The new information, referral, and follow-up service provides a central source of information on facilities for the handicapped in the city and its suburbs. Such facilities include diagnostic clinics, special classes, recreation programs, parent organizations, and services for children who have mental, physical, or emotional handicaps.

Among the Center's services will be the revision and distribution of the *Directories of Services for Handicapping Conditions.* For a copy, write: Information Center for Handicapped Children, 1619 M Street, NW, Washington, D.C. 20036.

* * *

Under the leadership of **Emerson R. Julian, MD,** an intensive drive began April 1 to reduce the incidence of tuberculosis in Baltimore city.

Dr. Julian accepted chairmanship of the task force test program, which will run for six weeks. Two mobile chest X-ray units have been supplied by the City Health Department. The test program will concentrate on the inner city, spreading out from the Model Cities area and operating from 15 locations.

As chairman of the City Council's Health Committee, Dr. Julian said that despite advances in treatment, Baltimore still ranks third in the nation in new, active cases of tuberculosis.

* * *

Maryland's rubella immunization program is now in its sixth month, and over 200,000 of the estimated 630,000 eligible school children in the state have received the vaccine. Almost all Maryland counties are involved in the program, which will end with the current school year. According to Howard J. Garber, MD, Chief of the Division of Communicable Diseases, Maryland State Department of Health, over 70% of the children in the schools where programs have been conducted have received the rubella vaccine.

The campaign to vaccinate school children against the disease is an effort to forestall an epidemic of German measles that could occur as early as 1970-1971.

* * *

Beginning in July, the American Academy of Pediatrics will operate a permanent office in Washington, D. C. The Washington office is an extension of the AAP's Department of Government Liaison, which was established and approved by the Academy's Executive Board in April. It will work closely with major federal agencies and congressional committees to encourage the development of comprehensive child health programs.

Mr. George Degnon has been named director of the Department of Government Liaison.

* * *

After 57 years of practicing medicine, **Norbert C. Nitsch, MD,** has decided to retire for a second time.

Several years ago, at the mandatory retirement age of 70, Dr. Nitsch left his position as coroner for the Western District of Baltimore city and physician for the Baltimore City Police De-

partment and moved to Rock Hall to enjoy his retirement. However, he found such a critical need for the services of a physician in lower Kent County that he reluctantly resumed his practice.

Dr. Nitsch is a member of the Medical and Chirurgical Faculty, the AMA, the Maryland Academy of General Practice, and the Kent County Medical Society.

* * *

Among the guest speakers at the first meeting ever held for university hospital emergency department directors at the University of Alabama Medical Center in March was **Robert Rutherford, MD,** of The Johns Hopkins University in Baltimore.

* * *

David T. Crawford, MD, has been named to serve on the Advisory Council on Hospital Licensing.

Dr. Crawford, of the Franklin Square Hospital in Baltimore, will fill the remainder of a five-year term left vacant by Ross Z. Pierpont, MD, who recently resigned.

* * *

J. Alex Haller, MD, of Baltimore, will participate in the Ciné Clinic at the 1970 Clinical Congress of the American College of Surgeons to be held in Chicago in October. The topic of his motion picture will be pectus excavatum.

* * *

The cancer programs at several Maryland hospitals were recently surveyed. Approval of these hospital programs was based on the level of excellence in relation to the established standards of approval stated in the American College of Surgeons' *Manual for Cancer Programs.*

The goal of the approvals program is a coordinated cancer activities program anchored to a systematized cancer registry in each hospital. The following hospital programs received approval for three years, when they will be surveyed again: **Baltimore City Hospitals, Greater Baltimore Medical Center, The Johns Hopkins Hospital** (provisional), **Sinai Hospital of Baltimore, Union Memorial Hospital, U.S. Public Health Service Hospital,** and **University of Maryland Hospital,** all of Baltimore, and the **United States Naval Hospital** in Bethesda.

* * *

A poll taken during the recent Congressional hearing into oral contraceptives showed that 18% of the women surveyed had abandoned taking oral contraceptives. A more recent survey, however, shows that only 13% of those surveyed gave up the pill during the previous two months, and 69% intended to continue taking it. Moreover, 17% of the "dropouts" had already decided to go back on the pill within a year, while another 26% are undecided about returning. Of those who gave up oral contraceptives, 87% changed to some other birth control method.

* * *

Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, has announced the approval of a plan by Bethlehem Steel to reduce the air pollution at its Sparrows Point plant. By updating and adding to existing environmental quality control facilities, all operations will be brought within the requirements of the state air pollution control regulations. The plan will be completed in 1973.

The Bethlehem plan for compliance is the eighth plan to be approved by the Department. Others include: Baltimore Gas and Electric Company, Potomac Electric Power Company, and the Western Electric Company.

* * *

A new 26-page handbook, *Tips on Athletic Training VIII,* is now available for team physicians working with young athletes in both high schools and colleges. The handbook is published under the auspices of the Committee on the Medical Aspects of Sports of the AMA.

It covers topics such as the health examination for athletic participation, physical readiness for football, hot weather hints, and a first-aid chart for athletic injuries.

For a copy of the handbook, write the AMA Order Department, 535 North Dearborn Street, Chicago, Ill. 61610. Single copies are 15 cents each.

* * *

Although the results of the Faculty's questionnaire are still being tabulated, the latest figures reveal that 1,160 questionnaires were returned—a little better than a 25% participation. Out of this total, 895 members indicated they read the *Maryland State Medical Journal,* 632 read *JAMA,* 937 read specialty journals (usually more than one), 610 read *Medical World News, Medical Times* is read by 364 members, 733 read *Medical Economics.* The low scorer on the poll is the *New England Journal of Medicine* which is read by only 287.

The tabulated results on the use of library facilities indicate that 97 members frequently use the facilities, 573 rarely utilize the facilities, and 457 never use them.

One thing to keep in mind about these results is that they are not necessarily a reflection of how the membership *feels* about a particular aspect of Faculty services. For example, if the library were more accessible to a greater percentage of the membership, both geographically and in hours open, the poll would have revealed a different picture.

A number of members indicated they use hospital libraries

—some of which in turn use our facilities in order to obtain the desired information and the physician member is never apprised of this situation.

The Faculty library is competently staffed and offers a number of services of which the membership may not be totally aware. Next time you want a bibliography, or some other information, call the library at 539-0872.

* * *

In a recent issue of FOCUS, the University of Maryland at Baltimore's bulletin, **John H. Moxley, III, MD,** Dean of the School of Medicine, was quoted as saying: "During the 70's medicine in general, and the University of Maryland in particular, will continue to focus on medicine's relationship to the quality of life. The organization and delivery of care will retain the center stage throughout the end of the 70's and on to the end of the century.

"Some pieces of the puzzle which will receive the focus of this medical school are: ambulatory care and its relationship to medical education; new networks of care involving affiliated hospitals; further increases in class size (probably to 200); physical expansion with completion of at least two new buildings (North Hospital and Howard Hall addition) and probably a third (a VA Hospital); continued curricular reform with increasing emphasis on individual curriculum for each student; and completion of the Community Mental Health and Retardation Center, which will represent a unique combination of community-university-state interests.

"The hallmark of medicine in the 70's will be change—hopefully occurring in a more manageable order than in the 60's."

The Director of the Hospital, **George H. Yeager, MD,** stated: "We may expect a number of trends observed in the 60's to continue and intensify during the 70's. These trends can be grouped in categories: 1) More patients with more severe illnesses will require more elaborate treatment facilities and specialized talents of physicians and supporting personnel. 2) Increasing numbers of nonemergency patients will seek care in our emergency facilities. We must plan facilities to handle the needs of these patients apart from emergency patients. 3) The hospital may be asked to provide preliminary and follow-up care to a defined geographic population. This, too, will require planning for facilities different from the traditional specialty clinics. 4) As the number of students increases, greater demands will be placed on the hospital for supportive facilities, including faculty offices and conference rooms.

"In addition, we must develop living quarters for house staff and nurses, and arrange for such needs as a local bank, post office, and restaurants."

* * *

The Maryland Association for Mental Health is again recruiting high school students for the Student Careers Program conducted in the state mental hospitals.

The purpose of the program, to be held from July 6 through August 21, is to encourage students to consider a career in the mental health field and to give them a more informed attitude toward mental illness. Students will work with mentally ill and retarded patients at Eastern Shore, Crownsville, Spring Grove, Springfield, Henryton, and Rosewood state hospitals as well as at the Sheppard and Enoch Pratt Hospital. Many of the students working at the state hospitals will live on the hospital grounds.

Under supervision at all times, the students will work as assistants in most treatment wards. The program will begin with an orientation at each hospital and will include lectures by the professional staff. Each student will receive a $175 stipend for the seven-week program.

* * *

The Johns Hopkins University School of Medicine has been awarded $389,754 by the John A. Hartford Foundation, Inc., of New York, to support mapping studies of human chromosomes.

Victor A. McKusick, MD, principal investigator for the project, stated, "It is our expectation that studies of this type will increase our understanding of hereditary diseases and improve our treatment for them."

Dr. McKusick is chief of the Division of Medical Genetics and director of the Moore Clinic at Hopkins.

* * *

Slight changes in blood cells may help physicians confirm kidney diseases early in the life of a child, reports a pediatrician from Georgetown University's School of Medicine.

Philip L. Calcagno, MD, professor and chairman of the Department of Pediatrics, said that a study of hereditary nephritis indicates that a particular combination of minute changes in the cells may be found frequently in early stages of the disease.

The changes noted were fetal-like glomeruli; a mild abnormal increase in the number of cells present; large numbers of tubules filled with red blood cells; foam cells in the gaps between fibers of the kidney, and identical findings in brothers and sisters of the patient. The researchers used unusual factors in the family history of the patients, clinical findings, functional data and studies of actual kidney specimens to reach their conclusions.

In one case, they were able to trace hereditary nephritis through four generations of the family.

The study by the Georgetown

Hospital researchers is believed to be one of the first reports on early symptoms noted in connection with the kidney disease.

* * *

Julius Loebl, MD, director of the Division of Maternal and Child Health Services of Anne Arundel County, during a panel discussion held in March of this year, said that adults are sticking their heads in the sand in failing to provide birth control information to teen-agers because withholding information will not prevent illegitimate births.

Stressing that he was speaking "unofficially", Dr. Loebl indicated that legislation is needed to change the law that physicians cannot treat minors without parental consent. He stated the "climate is not right" to initiate the change and urged the audience to spread the word and get the "climate right".

Dr. Loebl stated that 474 pregnant Anne Arundel County girls between 12 and 18 were reported to his department last year. The girls need help and counseling, he said, and the county Department of Education has been receptive to a proposal to establish a special school for the pregnant teen-ager.

* * *

The Executive Board of the American College of Obstetricians and Gynecologists has approved the following recommendations of the Committee on Obstetric-Gynecologic Practice:

—That Fellows of the College should be members of teams negotiating for the delivery of obstetric-gynecologic services, and that the AMA and state medical societies be advised of this.

—That insurance companies be urged to provide proportionately the same coverage for obstetric care as is provided for other medical and surgical procedures.

—That the College publicize the role of obstetrician-gynecologists in maternity care.

—That the AMA be asked to include obstetric-gynecologic representatives on present and proposed committees concerned with the delivery of health care.

—That problems of professional practice be discussed and seminars held on these subjects at national and district meetings.

* * *

The Johns Hopkins University has received a $975,000 grant from the Ford Foundation to partially support research and training in the Division of Population Dynamics. The grant will provide for staff, fellowships, and laboratory equipment for family-planning administration, demography and related social sciences, and the Laboratory of Reproductive Physiology.

The division is headed by Dr. Paul Harper, a principal architect of Pakistan's family-planning program. The reproductive physiology laboratory was established in 1966 under the direction of Dr. John Biggers, a distinguished developmental biologist.

Faculty research has centered on maturation of ova and sperm, fertilization, growth of fertilized ova before implantation, and the early stages of pregnancy.

* * *

"A Look at Sex Education in the School" is a new film available to medical societies and woman's auxiliaries. The 16 mm color film is a panel discussion of the AMA's resolution endorsing family life and sex education programs in the nation's schools.

Prints are available without charge, on loan, from the AMA Radio and TV Department, 535 North Dearborn Street, Chicago, Ill. 60610.

* * *



THE MONTH IN WASHINGTON

The House Ways and Means Committee approved legislation that would change the Medicare program to permit prepaid closed-panel group practice care and would set ceilings on physicians' fees under Medicare and Medicaid.

The committee did not consider national health insurance proposals for legislative action this year.

A proposal for inclusion of chiropractic under Medicare was rejected. However, a compromise provision would direct the Health, Education and Welfare Department to conduct a "very limited" study of chiropractic under Medicare, utilizing the experiences under Medicaid. Chiropractic now is a Medicaid service in 15 states, being authorized for federal funds to the extent that it is legal in the state. Representatives of chiropractors lobbied intensively with committee members for the same treatment under Medicare.

The committee also decided against inclusion of social security disabled beneficiaries under Medicare. Instead, the proposal was referred to the Health Insurance Benefits Advisory Council for further study.

The House was expected to approve the committee's bill, which included a 5% increase in cash social security benefits, without change. However, changes were expected in the Senate.

Provisions of the committee bill of major importance to physicians included:

● **Health Maintenance Organization Option:** Individuals eligible for both Part A and Part B Medicare coverage would be able to choose to have their care provided by a health maintenance organization (a prepaid group health or other capitation plan). The government would pay for such coverage on a capitation basis not to exceed 95% of the cost of Medicare benefits provided to beneficiaries in the area not covered under the health maintenance organization.) ● **Experiments and Projects in Prospective Reimbursement and Incentives for Economy:** The secretary of HEW would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under Medicare, Medicaid and maternal and child health. In addition, the secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy, and with community-wide utilization review mechanisms. ● **Limitation on Recognition of Physician Fee Increases:** Charges determined to be reasonable under the present criteria in Medicare, Medicaid, and maternal and child health law would be limited by providing: (a) that for fiscal year 1971 medical charge levels, recognized as prevailing, may not be increased beyond the 75th percentile of actual charges in a locality during calendar year 1969; (b) that for fiscal year 1972 and thereafter the prevailing charge levels, recognized for a locality, may be increased, on the average, only to the extent justified by increases in the cost of production of medical services, levels of living and the earnings of other professional, managerial and technical personnel; and (c) that for medical supplies, equipment and services that, in the judgment of the secretary, generally do not vary significantly in quality from one supplier to another, charges allowed as reasonable may not exceed the lowest levels at which such supplies, equipment and services are widely available in a locality. ● **Payments for Services of Teaching Physicians:** Medicare and Medicaid would not pay for the services of teaching physicians unless other patients who have insurance or are able to pay are also charged for such services and the Medicare deductibles and coinsurance amounts are regularly collected. Medicare attached payment would be authorized for services to hospital patients by staff of certain medical schools that now furnish these services without charge to the hospital. ● **Termination of Payments to Providers Who Abuse the Medicare Program:** The secretary of HEW would be given authority to terminate or suspend payment for services rendered by a supplier of health and medical services found to be guilty of program abuses. Program review teams would be established to furnish the secretary professional advice in carrying out this authority. ● **Repeal of Medicaid Provision Requiring Expanded Programs:** The requirement in present law that States have comprehensive medicaid programs by 1977 would be repealed. ● **Prohibition of Reassignments:** Medicare and Medicaid payments to anyone other than a patient or his physician would be prohibited, unless the physician is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services. ● **Utilization Review in Medicaid:** Require hospitals and skilled nursing homes participating in the Medicaid and maternal and child health programs to have the same utilization review committee with the same functions as in the Medicare program. ● **Role of State Health Agencies in Medicaid:** State health agencies would be required to perform certain functions under the Medicaid and maternal and child health programs relating to the quality of the health care furnished to recipients. ● **Physical Therapy Services Under Medicare:** Under Medicare's supplementary medical insurance program, beneficiaries would be covered for up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's prescription. Hospitals and extended-care facilities could continue to provide covered physical therapy services to patients who have exhausted their days of hospital insurance coverage. ● **Chiropractors' Services:** HEW would conduct a study on covering chiropractors' fees (on a very limited basis) under Medicare, utilizing the experimental authority under the Medicaid program. A report on the study, including the experience of other programs paying for chiropractors' services would be submitted to the Congress within two years.

* * *

The American Medical Association expressed opposition to a proposed oral contraceptive package insert addressed to users.

The Food and Drug Adminis-

tration first proposed a package insert of about 700 words dealing with possible side effects and potential dangers of taking birth control pills. When this raised widespread opposition, the FDA drastically revised the original draft, cutting it down to about 100 words. Main objections to the first draft were that it was too long and detailed to be addressed to a patient and that it raised a serious question about the relationship between physician and patient.

After the FDA invited comments on the revised draft from interested parties, Ernest B. Howard, MD, executive vice president of the AMA, responded that the AMA opposes any oral contraceptive package insert. He said that, "in the best interests of the patient and the practice of quality medicine," there should be no package insert addressed to users.

". . . The requirement that information on the side effects of a prescription drug be supplied directly to the patient is a dangerous departure from present practice," he said in a letter to the Health, Education and Welfare Department, of which FDA is a part. "It intrudes upon the patient-physician relationship and compromises individual medical evaluation. The proposed statement would lead to confusion and alarm among many patients and could result in harm to some.

"For these reasons, the American Medical Association is opposed to a package insert directed to patients for any prescription drug.

"The oral contraceptive is a prescription drug. It is the responsibility of the physician to inform his patients of the potential hazards of drugs he prescribes. In counseling on family planning, the physician has a further responsibility. He should provide information that will enable the patient to make an intelligent decision regarding the use of oral and other contraceptive methods.

"The proposed statement, in its simplistic approach to a complex situation, would confuse the patient who has already been informed of possible side effects by her physician and who has received her physician's recommendation as to a desirable method of contraception for her. . . .

"A stated purpose of the insert is to reinforce the efforts of the physician to inform the patient in a balanced fashion of the risks. The physician has a duty to weigh the benefits against the possible risk in prescribing any drug for a patient, and the physician's advice to the patient in connection with the drug prescribed must be individualized for each patient. The balanced fashion theory cannot be a part of good therapeutic practice, which requires an individual judgment for each patient. Standardized information could harm some patients by limiting the value of the specific information given to them by physicians.

"A package insert is an inappropriate and ineffective means of providing a patient with information regarding any prescription drug. The best way to inform patients effectively is through the physician. The best way to reinforce the physician's efforts to inform the patient is to provide him with unbiased, authoritative and up-to-date information. Our Council on Drugs has used the *Journal of the American Medical Association* for this purpose. Further, in a forthcoming book titled *AMA Drug Evaluations*, we will supply the physician with comprehensive information on oral contraceptives, as well as on other drugs. We would be pleased to join with the Food and Drug Administration and other concerned medical and scientific organizations in the preparation of any additional information, and to provide a means of placing it in the hands of all physicians. . . ."

* * *

The American Medical Association supported two Senate bills (S. 3297 and S. 3652) that would require labeling of prescription drug containers except where the prescribing physician indicated otherwise.

"We would emphasize very strongly, however," John J. Curry, MD, a member of the AMA Council on Drugs, testified at a Senate Health Subcommittee hearing, ". . . that both bills fall short of the recommendation of the American Medical Association. In urging your support of labeling legislation, we strongly recommend that the legislative requirement provide that the label contain the established name or trade name of the drug as written by the physician, or, in the case of a combination drug, the established name of the active ingredients of the drug or its trade name as written by the physician, and the quantity and strength of the drug. Provision should, of course, be made that the label would not contain any or all of the foregoing information where the physician so indicates."

The AMA also supported S. 3096 and another provision of S. 3297 that would require a coding identification on each tablet, capsule or other final form of a medication.

The AMA did not take a position on a fourth bill (S. 3651) that would require inspection of drug manufacturing firms every six months, instead of the present two years. Dr. Curry said that he was concerned that medications he prescribed "are of maximum purity and manufactured under proper controls," but that he was not qualified to speak on the length of time between inspections.



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Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

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942

Research in the Service of Medicine



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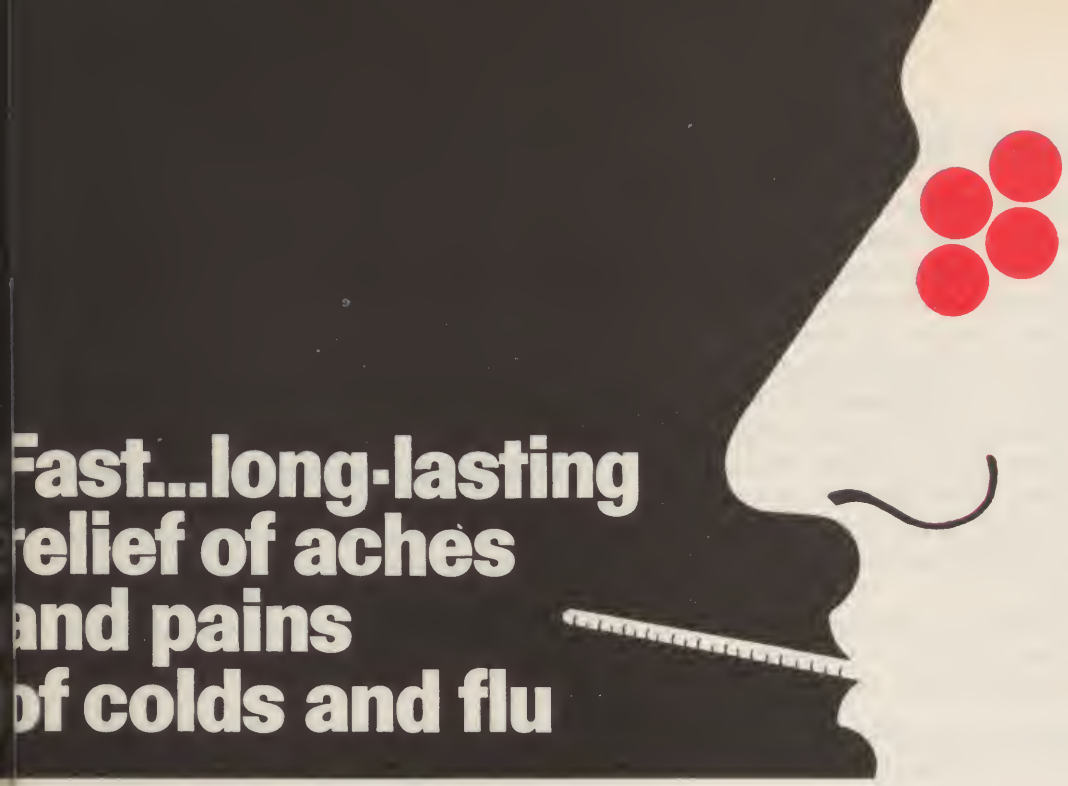
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Be sure that statistics are consistent in both tables and text.

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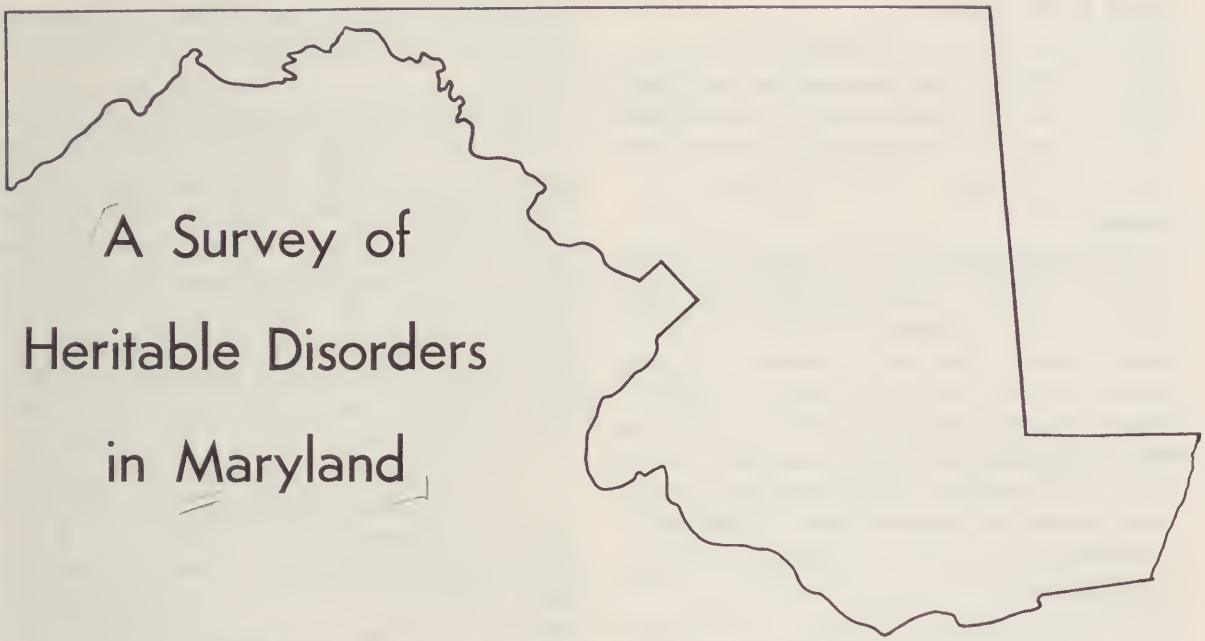
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A Survey of Heritable Disorders in Maryland

Chronic diseases are recognized as a major challenge in the United States today. A rapid increase in research discoveries and an awareness of the value of genetic counseling have heightened interest in medical genetics. As a result of this trend, at least 15 state health departments have started programs in genetics.[1] The present study was undertaken in collaboration with the Maryland State Department of Health as a preliminary step in expanding health services in genetics. It is concerned primarily with disorders inherited in a Mendelian manner or with chromosomal aberrations. Some data are available for the incidence of congenital malformations[2,3,4,5,6] and for the more common conditions with genetic components,[2,7,8] but there are few statistics for the prevalence of rare disorders which follow simple Mendelian inheritance.[9] The proportion of congenital malformations so far described which "mendelize" is also unknown.

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Object of the Survey

The purpose of the investigation has been to assess the minimal dimension of the health problem due to genetic disorders and to explore facilities in the state for investigation, treatment, counseling, and follow-up of affected persons.

Method

Selection techniques for rare traits were recently reviewed by Kish.[10] Methods used in this survey resemble those designated by Kish as most effective, namely, the use of special lists which contain one rare class, supplemental samples to locate the units which are missing from the lists, and the separation of special strata which contain most of a rare class. The following resources were screened for selected genetic disorders:

1. Rosewood and Henryton State Hospitals, institutions for the mentally deficient
2. Children's Hospital, dealing particularly with musculoskeletal abnormalities
3. Specialty clinics in Baltimore hospitals: muscular dystrophy, cystic fibrosis, diagnostic and evaluation and birth defects clinics
4. Cytogenetic laboratories
5. The Maryland State Department of Health: phenylketonuria registry, diagnostic and advisory team, the 23 county health departments and Baltimore City Health Department
6. The Bureau of Vocational Rehabilitation registry of the blind
7. Maryland School for the Deaf
8. Baltimore League for Crippled Children and Adults

Data on selected heritable disorders were collected from August through November, 1967. Name, birth date, race, and sex of patients were recorded when official policy permitted. Nonspecific diagnostic categories or lack of diagnostic indexing and computerized data and retrieval systems imposed limitations to the collection. Diagnoses from cooperating facilities which had usable record systems were converted to the coding of the INTERNATIONAL CLASSIFICATION OF DISEASES, ADAPTED (I C D A [11]) and MENDELIAN INHERITANCE IN MAN (M I N [12]). Approximately 6,000 hospital, clinic, laboratory, and agency records were examined.

In addition, several agencies provided counts or estimates of the prevalence of specified conditions although the individual records were not made available to the investigator. A description of the data available from each of the facilities follows.

Rosewood and Henryton Hospitals are the two institutions designated by the state for custodial care of the mentally retarded. Rosewood had 2,852 patients of whom almost three quarters were in the age group 5 to 24 years. Henryton had 405 patients 18 years of age and over. The records of these two facilities were searched for patients with genetic disorders who were in resident, foster, or convalescent care in 1967. Identifying information was available for cross-checking with lists from other facilities.

Children's Hospital data are based on 24,999 orthopedic admissions between 1955 and 1967, indexed by diagnosis. The names of the individuals were not available so there may be multiple ascertainment of some persons. This will result in overcounts of some conditions, as estimated from this facility.

Among the specialty clinics, the Diagnostic and Evaluation (D and E) Clinic at The Johns Hopkins Hospital and at the University of Maryland are referral clinics for children with multiple handicaps. A major portion of the children are mentally retarded. The Diagnostic and Advisory (D and A) team of the State Health Department is involved with problems similar to those of the hospital D and E clinics. The team travels to eight Maryland counties reviewing diagnostic problems for referral to medical centers. The records were extracted from these clinics and the names of those with genetic conditions were checked with those of other facilities.

It is estimated that about 75% of Maryland patients with muscular dystrophy and cystic fibrosis attend the two specialty clinics for these diseases at The Johns Hopkins Hospital. Between 1960 and 1967, 150 muscular dystrophy cases were in follow-up at the muscle clinic. The cystic fibrosis clinic had 128 patients registered between 1959-1967 of whom 60% were in follow-up at the date of the study. These counts were obtained from unpublished reports from the clinics.

Patients needing treatment for congenital defects are eligible to attend the National Foundation-March of Dimes birth defects treatment center at The Johns Hopkins Hospital. The names of these persons were extracted, and also checked against those of other facilities. The State Department of Health phenylketonuria registry reported 79 resident cases of phenylketonuria.

A review of the work of the cytogenetics laboratories in the state revealed that much of the work is research rather than service-oriented and therefore not suitable for obtaining estimates of frequency of genetic disorders.

County public health officers and nurses were asked to fill out the form presented in Figure 1. These forms provided estimates of the number of persons known to be affected with the specified heritable disorders. The Baltimore City Health Department provided counts of the number of cases according to the selected diagnoses from their Handicapped Children's Program in 1966 and 1967.

Figure 1: THE MOORE CLINIC
THE JOHNS HOPKINS HOSPITAL
Baltimore, Maryland 21205

Have you observed any of these hereditary disorders in .....County?	No. of Cases
1. Albinism	
2. Anemia of hereditary type	
3. Blindness, congenital or early in onset, partial or complete	
4. Cataract, congenital or juvenile	
5. "Cerebral palsy"	
6. Cretinism	
7. Cystic fibrosis of the pancreas	
8. Deaf-mutism	
9. Dwarfism, any type	
10. Goiter with childhood onset	
11. Hand malformations	
12. Heart malformation, any type	
13. Hemophilia and other bleeding disorders	
14. Hydrocephalus	
15. Jaundice with or without hemolytic anemia	
16. Mental retardation, any type	
17. Mongolism	
18. Muscular dystrophy, any type	
19. Nephritis	
20. Neurologic disorders, such as Friedreich's ataxia	
21. Phenylketonuria	
22. Polydactyly	
23. Retinitis pigmentosa	
24. Sex disorders	
25. Skin ailments, congenital, any type	
TOTAL	

Have you observed other types of hereditary disorders? Any disorder which seems to "run in the family" will be of interest to us.

The Bureau of Vocational Rehabilitation reported a current register of 1,483 blind persons. Registration of the blind by the Bureau of Vocational Rehabilitation was established as a Federal project in September 1966 and is maintained up-to-date. Cases are ascertained throughout the State from hospital records, ophthalmologists, optometrists, the Maryland School for the Blind, and the Workshop for the Blind.

The Maryland School for the Deaf provided statistics on the number of children enrolled in the school in September 1967 who had a family history of deafness or diagnosis of a condition known to be genetic.

The registry of the Baltimore League for Crippled Children and Adults was reviewed for genetic conditions and screened for duplication of names on the other study lists. Most of the registrants were adults.

Results

Table I gives the results of review of 6,182 records from seven facilities. Heritable conditions are grouped according to the genetics of the abnormalities: established Mendelian disorders, possible Mendelian disorders, mongolism, and other chromosomal aberrations. The genetics are not clear for unclassified congenital malformations, unclassified congenital deafness, microcephaly without other malformations and familial mental retardation.

Tables II-A, B, and C present frequency distributions for established Mendelian disorders by mode of inheritance. The data are from Children's Hospital and the seven selected health facilities of Table I. Children's Hospital data are examined separately because of the chance of multiple listing of an affected person when identifying information is used as diagnosis alone.

There were 27 autosomal dominant conditions reported in 81 persons of which tuberous sclerosis with 24 cases and neurofibromatosis with 13 cases were the most common. A total of 28 autosomal recessive conditions were reported in 102 persons of whom 48 had phenylketonuria. Among the seven X-linked conditions reported in 12 persons, six were muscular dystrophy (Duchenne type).

In addition, 12 autosomal dominant conditions in 75 diagnoses, 12 autosomal recessive in 50, and three X-linked conditions in 23 were reported from the Children's Hospital. These are somewhat different conditions than those reported by the other facilities as might be expected from the nature of the facilities. The most prevalent diagnoses of dominant conditions were Charcot-Marie-Tooth disease with 20 diagnoses and osteogenesis imperfecta with 17. Among the recessive conditions, limb girdle muscular dystrophy was the most common, occurring 14 times. Of the 23 diagnoses of X-linked conditions, 18 were hemophilia A or B.

TABLE I

Percent Distribution of Genetic Disorders
Among All Cases Reported by the Facility, by Mode of Inheritance
In 7 Maryland Facilities

Genetic Inheritance	State Hospital: Rosewood (1967)	State Hospital: Henryton (1967)	D and E Clinics: Johns Hopkins Hospital (1966)	D and E Clinics: University Hospital (1956-66)	D and E Clinics: D and A Team S.H.D. (1966)	D and E Clinics: Birth Defect Clinic Johns Hopkins Hosp. (1967)	D and E Clinics: Balto. League for Crippled Children and Adults (1967)
Established Mendelian Disorders	2.66	1.7	2.48	1.62	1.87	32.58	7.04
Possible Mendelian Disorders	0.49	10.0	4.02	0.49	1.87	9.95	4.57
Chromosomal Aberrations, Including Mongolism	5.58	13.8	2.17	1.28	3.74	2.24	0
Congenital Anomalies	1.11	10.0	4.02	1.43	7.47	20.79	0
Congenital Deafness	N.A.*	N.A.	5.26	2.11	N.A.	N.A.	N.A.
Microcephaly without other malformations	6.20	6.20	5.26	1.03	N.A.	N.A.	N.A.
Familial Mental Retardation (without a known syndrome of metabolic defect)	12.38	15.0	N.A.	N.A.	N.A.	N.A.	N.A.
Total Percent Classified as Genetic	28.41	37.20	23.22	7.69	14.95	65.56	11.61
NUMBER OF CASES	2852	405	323	2033	107	178	284

TOTAL CASES: 6182

* Data not available.

TABLE II-A

Frequency of Selected Established Mendelian Disorders by Mode of Inheritance As Determined From Record Services of Two State Hospitals, Three Diagnostic Clinics, Birth Defect Treatment Center, and A Children's Orthopedic Hospital

Number of Persons

Mode of Inheritance: Autosomal Dominant	State Hosp.: Rosewood (1967)	State Hosp.: Henryton (1967)	D and E Clinic: J.H.H. (1966)	D and E Clinic: U. Hosp. (1965-66)	D and E Clinic: D and A Team S.H.D. (1966)	D and E Clinic: Birth Defects Treat. Ctr. J.H.H. (1963-67)	D and E Clinic: Balto. League for crippled children and adults (1967)	Total	Children's Hosp. (No. of Diagnoses)
Achondroplasia	2			1		2	1	6	10
Acrocephalosyndactyly	2							2	
Alzheimer's disease							1	1	
Amyotrophic lateral sclerosis									1
Cerebellar ataxia				1				1	
Charcot-Marie-Tooth disease							1	1	20
Cleidocranial dysostosis				1				1	2
Duane syndrome				1				1	
Dyschondrosteosis			1					1	1
Fibrodysplasia ossificans progressiva									1
Holt-Oram syndrome							1	1	
Ichthyosis	1			1				2	
Mandibulofacial dysostosis	3			1				4	3
Marfan's syndrome	1						1	2	6
Moebius syndrome				1				1	
Muscular dystrophy, facio-scapulo-humeral				1				1	
Myasthenia gravis							2	2	
Myotonia congenita						1		1	4
Myotonic dystrophy						2		2	1
Neurofibromatosis	4	1	1	4		1	2	13	9
Osteogenesis imperfecta				1			4	5	17
Pelizaeus-Merzbacher disease				2				2	
Radio-ulnar synostosis					1			1	
Sickle cell trait				1				1	
Spastic paraplegia, familial				2		2		4	
Tuberous sclerosis	18	1				5		24	
Waardenburg's syndrome						1		1	
TOTAL No. of cases	31	2	2	18	1	14	13	81	75

TABLE II-B

Number of Persons

Mode of Inheritance: Autosomal Recessive	State Hosp.		D-E Clinics						
	Rosewood (1967)	Henryton (1967)	J.H.H. (1966)	U. Hosp. (1965-66)	D and A Team S.H.D. (1966)	Birth Defects Treat. Ctr. J.H.H. (1963-67)	Balto. League for crippled children and adults (1967)	Total	Children's Hosp. (No. of Diagnoses)
Albinism	3							3	1
Amaurotic idiocy, juvenile type	2							2	
Amyotonia congenita							2	2	
Arthrogryposis multiplex congenita							1	1	
Chondrodystrophia calcificans congenita	1							1	
Cystic fibrosis									4
Ellis-van Creveld Syndrome									2
Friedreich's ataxia	1					2	1	4	5
Galactosemia			1					1	
Gaucher's disease									5
Glycogen storage disease	1							1	
Hallervorden and Spatz sydrome				1		1		2	
Hartnup's disease						1		1	
Hurler syndrome (M P S I)	1		1	2				4	6
Ichthyosis erythroderma				1				1	
Laurence-Moon-Biedl syndrome	1	1						2	
Metachromatic leucodystrophy (adult and infantile)	3					1		4	
Morquic syndrome							1	1	3
Muscular atrophy (infantile)						5		5	
Muscular dystrophy (limb girdle)	1	1						2	14
Myoclonic epilepsy of Unverricht									1
Phenylketonuria	22	1				25		48	7
Pituitary dwarfism, Type I and II	2	1		5				8	
Renal glycosuria				1				1	
Sickle cell anemia				2				2	
Thrombocytopenia									1
Thyroid hormonogenesis, defect in all types	2	2		1				5	1
Wilson's disease	1							1	
Total Number of Cases	41	6	2	13		35	5	102	50

TABLE II-C

Number of Persons

Mode of Inheritance: X-linked conditions	State Hosp.		D-E Clinics						
	Rosewood (1967) Henryton (1967)		J.H.H. (1966)	U. Hosp. (1965-66)	D and A Team S.H.D. (1966)	Birth Defects Treat. Ctr. J.H.H. (1963-67)	Balto. League for crippled children and adults	Total	Children's Hosp. (No. of Diagnoses)
Cerebral sclerosis, diffuse (Pelizaeus-Merzbacher form)									1
Hemophilia A or B									18
Hunter's syndrome (M P S II)		1						1	
Hydrocephalus						2		2	
Lowe's syndrome		1						1	
Muscular dystrophy, Duchenne type				3		1	2	6	4
Nyhan's syndrome		2						2	
Total Number of Cases		4		3		3	2	12	23

TABLE III

Prevalence of Genetic Disease as Reported
By 16 of the 23 Counties of Maryland (Exclusive of Baltimore city)

Mode of Inheritance			Total
Autosomal Dominant	Goiter with childhood onset	5	
	Nephritis	35	
	Polydactyly	54	94
Autosomal Recessive	Albinism	30	
	Cataract, congenital or juvenile	58	
	Cretinism	15	
	Cystic fibrosis of the pancreas	33	
	Deaf-mutism	122	
	Phenylketonuria	25	
	Retinitis pigmentosa	3	286
X-Linked	Hemophilia and other bleeding disorders	31	31
Autosomal Dominant or Autosomal Recessive	Dwarfism	50	
	Hand malformations	72	
	Heart malformations	314	436
Autosomal Dominant or Autosomal Recessive or X-Linked	Anemia of hereditary type	80	
	Blindness, congenital or early; partial or complete	121	
	Muscular dystrophy	69	
	Neurological disorders	428	
	Skin ailments, congenital	58	756
Autosomal Recessive or X-Linked	Hydrocephalus	64	
	Jaundice with or without hemolytic anemia	12	76
Chromosomal Aberrations	Mongolism	217	
	Sex disorders	39	256
Unclassified	Mental retardation, any type	2230	
	"Cerebral palsy"	299	2529
	Grand Total		4464

TABLE IV

Baltimore City Health Department

Number of children newly registered in the Handicapped Children's Program (HCP) according to primary diagnosis of genetic condition, July 1, 1965-June 30, 1967.

Diagnostic Code, HCP	Primary diagnosis of genetic condition	No. of Cases
019	Other endocrine diseases	24
020	Other metabolic and nutritional disease	07
021	Sickle cell anemia	22
022	Hemophilia	01
023	Other disease of blood and blood-forming organs	11
024	Mongolism	30
033	Other disease of nervous system	44
056	Cystic fibrosis	10
062	Disease of skin and cellular tissue	21
069	Certain disease of bones and joints	06
071	Progressive muscular dystrophy	04
079	Other disease of musculo-skeletal system	60
082	Congenital cataract	10
083	Congenital ptosis of eyelid	07
101	Chondrodystrophy	02
102	Osteogenesis imperfecta	102
104	Other congenital malformations of bone and joint	20
105	Webbed fingers and/or toes	04
106	Other congenital malformations	93
	TOTAL	478

Table III summarizes the County Health Departments' estimates of prevalence of genetic disease. Sixteen out of 23 counties, exclusive of Baltimore city, reported 4,464 cases. Baltimore City Health Department data were primary diagnoses of newly registered children from the Handicapped Children's Program July 1965 through June 1967 (Table IV). Almost 11% of these 3,475 newly registered children had diagnoses attributable to genetic etiology. Comparable figures for all children in the program were not available.

Table V shows the number of cases of blindness of probable or possible hereditary origin listed on the Vocational Rehabilitation's Registry of the Blind by diagnosis and by whether the condition was one in which other cases were reported in blood relatives. For 37 cases familial occurrences were reported. There was no other case in the family in 31 cases and for 224 of the cases it was not known whether familial cases were present or not.

TABLE V

Number of Cases by Diagnosis On the Vocational Rehabilitation's Registry of the Blind, 1967

Abnormality	Family History		
	Positive for other cases	Negative for other cases	Unknown
Achromatasia (Congenital Cone defect)	0	0	2
Albinism	3	0	17
Cataracts, congenital	2	0	20
Cataracts, congenital with nystagmus	0	0	12
Glaucoma, infantile: with cataracts	0	0	3
without cataracts	0	0	20
Macular degeneration	3	0	8
Microphthalmos	0	0	3
Myopia, high: with degeneration	2	0	0
without degeneration	0	0	3
Nystagmus, congenital	2	0	10
Ocular anomalies, multiple congenital	0	13	10
Optic atrophy	3	7	10
Retinitis pigmentosa: typical	10	0	55
atypical	3	0	0
All other conditions	9	11	51
TOTAL NUMBER OF CASES	37	31	224

Table VI and Figure 2 show the classification of 102 children with known hereditary deafness and probable hereditary deafness reported from a total enrollment of 295 deaf children in 260 families from age 5 in kindergarten to age 17 to 19 years in the 12th grade.

TABLE VI

Classification of children with known hereditary deafness and probable hereditary deafness, enrolled in the Maryland School for the Deaf, 1967.

Heredity	Number of Children	Number of Families
Known genetic syndrome (Waardenburg's syndrome Laurence-Moon-Biedl, etc.)	9	9
More than 1 generation of affected individuals	62	38
Parents normal, but affected sibs	31	21
TOTAL	102	68

Table VII presents counts of cases of three conditions, phenylketonuria, cystic fibrosis and muscular dystrophy, reported by the State Health Department and The Johns Hopkins Hospital specialty clinics for cystic fibrosis and muscular dystrophy, respectively. These represent frequency of diagnosis over the periods of time specified in the table.



Figure 2. Pedigree of familial deafness among pupils at the Maryland School for the Deaf.

TABLE VII

Number of cases of phenylketonuria (PKU), muscular dystrophy and cystic fibrosis of the pancreas from special files.

	Number of cases	Period of time covered
PKU Registry, MSDH	79	1967
Cystic fibrosis clinic J.H.H.	128	1959-1967
Muscular dystrophy clinic J.H.H.	150	1960-1967

Discussion

The data presented represent the total number of reports of persons with heritable disorders or, for Children's Hospital, the total number of diagnoses when the known duplications have been removed. For some of the reporting agencies the numbers clearly are measures of prevalence, ie, the number of cases existing at the time of the study. The data from the two State mental institutions, the Bureau of Vocational Rehabilitation (B.V.R.), the Maryland School for the Deaf, and the Baltimore League for Crippled Children and Adults are of this type. However, the prevalence in mental institutions must be supplemented by counts from the noninstitutionalized population if estimates for the entire state are to be obtained.

The registry of the blind maintained by the B.V.R. may be assumed to contain a reasonably accurate list, at least of the genetically determined types of blindness, except that the registry may not have been in operation long enough to have completed the ascertainment of all cases in the community.

The Maryland School for the Deaf records are limited (1) to school-age children, and (2) to children attending this school. Deaf children who may be in other schools or institutions have not been counted.

Reports from the remainder of the facilities (except for Children's Hospital) constitute incidence, ie, number of diagnosed new cases occurring during a period of time. The period of time varies from one to nine years. The age span covered by these facilities is childhood for the D and E, and D and A clinics, and all ages for the others. Furthermore, Children's Hospital data give incidence of diagnoses rather than incidence of prevalence of persons with the conditions. The age span covered is childhood.

Also, the City Health Department's counts represent incidence of the reported conditions. They are counts of children newly registered in the Handicapped Children's program and do not include all children in the program. Furthermore, the children in the program represent an unknown proportion of all children with the conditions. On the other hand, the reports from the counties are probably prevalence plus some previously known cases who are now dead or are no longer in the area. These are deficient because (1) only 16 of the 23 counties are represented, and (2) they represent only cases known to the health departments.

It is obvious that some persons may have been counted in both incidence and prevalence figures, for example, at a diagnostic clinic and at a mental hospital, but these cannot be sorted out without the name and identifying information for each individual, which were not available. There are some conditions for which this duplication may be great, such as mental retardation, ataxia, and chromosomal abnormalities, and some, such as muscular dystrophy, for which it may be minor.

The data do provide minimum estimates of incidence and of prevalence, although even without duplication it would be difficult to put such figures together into a single measure of the frequency of such conditions. The variability in diagnosis, in ascertainment probability, in availability of facilites, in eligibility for use, and in willingness to use the facilities in addition to the measurement problems discussed above all make it impossible to pool the counts into summary figures. It is more useful, perhaps, to consider the data as providing measures of the demand on these facilities by persons with genetic conditions.

Recommendations

It is recommended that the State Department of Health through its local subdivisions take fuller advantage of available services in medical genetics at the University Hospital, Sinai Hospital and The Johns Hopkins Hospital by direct referral of persons with genetic disease. In addition, a state registry of reportable genetic disorders is advocated as an adjunct to epidemiological methodology for study of control and prevention of heritable disorders.

Summary

The results of the survey provide minimal prevalence and incidence information on heritable disorders in Maryland. The University Hospital, Sinai Hospital and The Johns Hopkins Hospital have facilities for the study of genetic disease with diagnosis, management, genetic counseling and long-term follow-up of patients and families. A fuller utilization of these university and hospital centered medical genetic clinics by local Health Departments is urged and a registry of reportable genetic diseases is recommended as a method for compiling epidemiologic data applicable to the long-range goal of control and prevention of heritable disorders.

References will be supplied upon request.

The Number of Children and the Supply of Physicians in Maryland Since 1940

In an earlier review (January 1968 pp 66-69) we found that one half of the general practitioners in the State of Maryland were 57 years of age or over. Pediatricians comprised only 19% of the physicians in the state giving primary care to children. The number of pediatricians entering practice in large metropolitan areas in the most recent cohort fell below previous age cohorts. From this kind of information we concluded that present educational facilities and present patterns of recruitment or of practice would not satisfy the increasing demand for physicians to provide medical care for children in private offices.[1]

The Committee on Medical Care of the Maryland State Planning Commission had at that time received reports of shortages of physicians which are understood to be problems in distribution. To study patterns of distribution we reviewed population changes for each county in Maryland and compared them with the number of pediatricians and general practitioners in the same counties.

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ACKNOWLEDGEMENT

Mrs. Rose Powdermaker carried out the counting of physicians by their community of practice and their specialty. Many of these physicians were known to her as students at the University of Maryland, where she has been a secretary since 1945.

Population Growth in Maryland

Inspection of the United States census data for the counties of Maryland reveal that population growth has been unevenly distributed among the counties. Eight counties in Maryland more than doubled their population of children in the 20 years between 1940 and 1960.[2] They were, in order of size of increase: Charles, Howard, St. Mary's, Harford, Anne Arundel, Baltimore, Prince George's, and Montgomery counties. The latter quadrupled its child population. Figure I shows how these counties are grouped around Baltimore, Annapolis and Washington, D.C. Since their rate of population increase is greater than the national average we may assume that much of their growth is due to immigration of persons rather than simply due to birth of children. They are counties in transition from agricultural to industrial and suburban economic patterns. They participate in the creation of the "megalopolis" of the middle eastern United States.

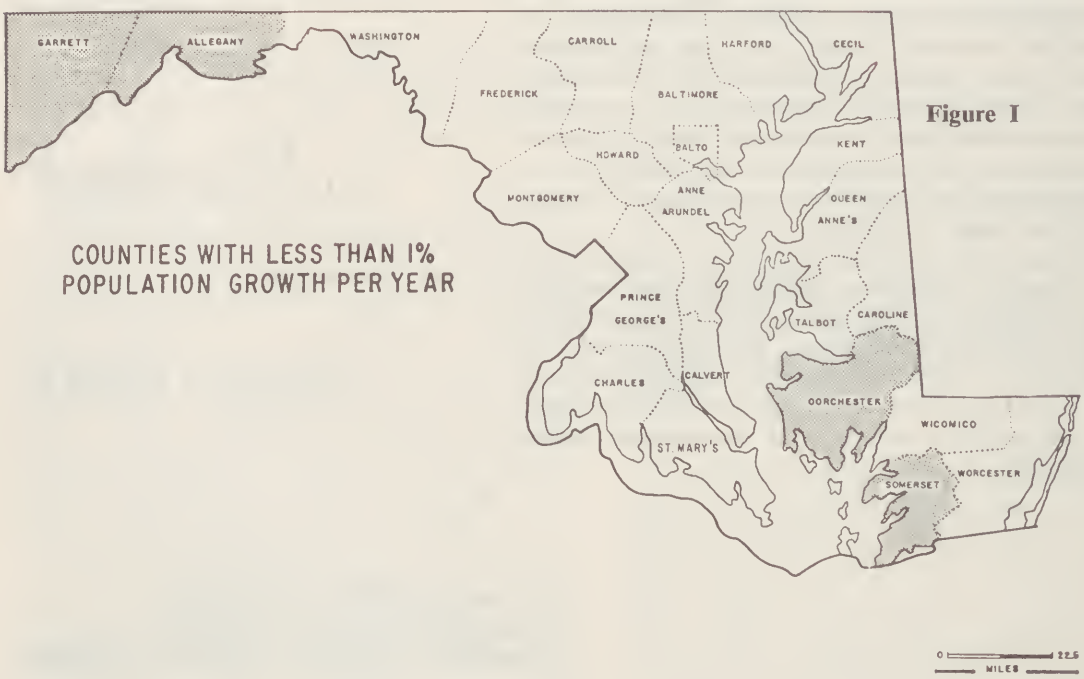


Figure I

In Figure II we can look at the counties in which the population of children less than 18 years of age increased at less than 1% per year over the past 20 years. They are the two mountainous western counties and two rural counties along the Chesapeake Bay. The population actually decreased in Garrett and Somerset counties. This suggests that Maryland's population pattern in this period of time has been one of movement of families from rural areas into industrial, urban, and suburban communities.

The Number of Physicians for Primary Care of Children

Primary medical care may be defined as the initial source of care for a majority of health and medical problems. Secondary medical care usually refers to care given by medical specialists upon referral from a source of primary medical care. General practitioners and pediatricians are the usual providers of primary medical care for children. In the past two decades pediatricians have provided primary medical care for about 20% of the children in the nation.[3] A number of trends are related to the reduced availability of general practitioners for the remainder of the children.[1,4] Outpatient Departments, Emergency Rooms, and Well Baby Clinics have assumed an increasing proportion of the primary care functions for children. Alternatives available to the community in the absence of general practitioners as a source of primary care include: 1) increased availability of pediatricians, 2) increased use of specialty services by families with

children without referral, 3) increased use of Outpatient Departments and Emergency Rooms for general pediatric care, or 4) new forms of primary medical care for children.

To calculate ratios between the number of physicians and the number of children we enumerated physicians by location, specialty, and birth date in the GEOGRAPHIC REGISTER of the American Medical Association for the appropriate years.[5] The numbers of children under 18 years of age for each county were obtained from CHARACTERISTICS OF THE POPULATION by the U.S. Census for the appropriate year.[2]

The decreasing availability of general practitioners to children in Maryland can be seen in Table 1. In 1940 there was a ratio of one general practitioner to every 430 children in Maryland. In 1960 the ratio was one general practitioner to every 1,490 children.

TABLE 1

RATIO OF GENERAL PRACTITIONERS TO CHILDREN IN MARYLAND

Year of Census	Ratio
1940	1:430
1950	1:474
1960	1:1490

The availability of pediatricians to children in Maryland increased 12% from 1:7000 in 1940 to 1:6170 in 1960 as can be seen in Table 2. During the same period of time the ratio of all physicians in Maryland to children decreased as may be seen in Table 3. The ratio of 1 physician to 177 children changed to a ratio of 1 physician to 259 children. We should remind ourselves that the numerator for physicians in all forms of practice includes an increased proportion of physicians, interns, residents, medical school teachers, and administrative physicians.[6]

TABLE 2

RATIO OF PEDIATRICIANS TO CHILDREN IN MARYLAND

Year of Census	Ratio
1940	1:7000
1950	1:6950
1960	1:6170

TABLE 3

RATIO OF PHYSICIANS (All Forms of Practice) TO CHILDREN IN MARYLAND

Year of Census	Ratio
1940	1:177
1950	1:207
1960	1:259

Geographic Location of Physicians in Maryland

The population shift from rural and small communities to urban and suburban communities is

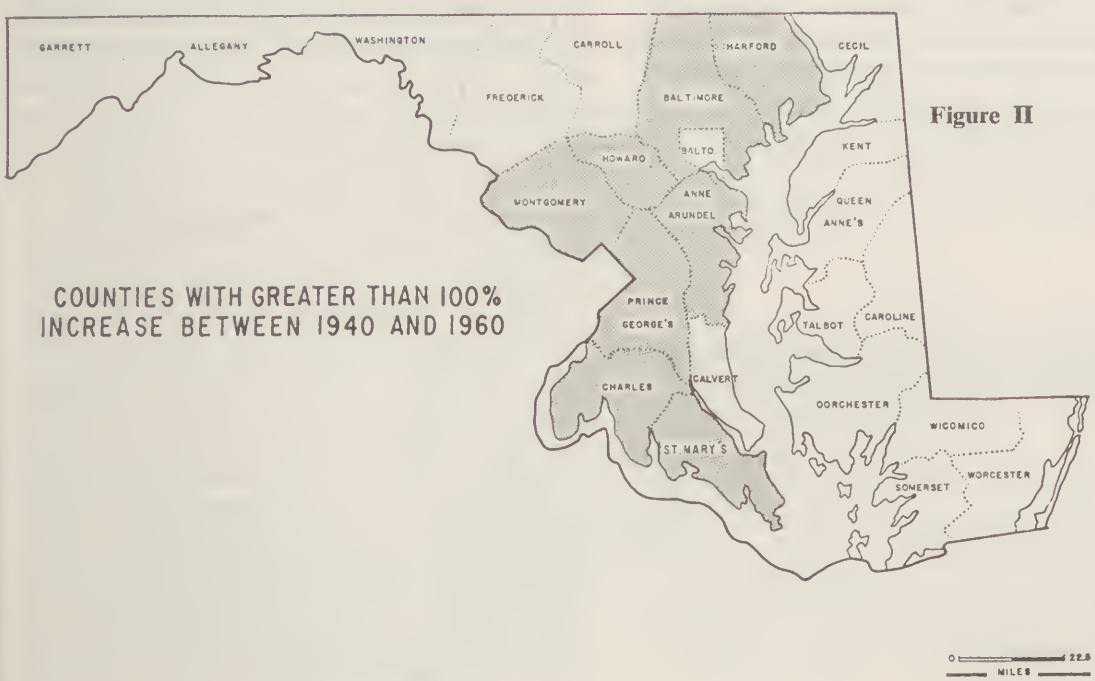


Figure II

not necessarily paralleled by changes in the number of primary-care physicians in the same communities. Table 4 shows the 30% decrease in primary-care physicians in communities under 1,000 in population which parallels the rural to urban shift, but the largest decrease in number of primary-care physicians is in the large city. Communities with populations between 5,000 and 10,000 are the only class of communities that has had an increased number of primary-care physicians and that increase is negligible. This is supported by an earlier study of the location of young physicians in which the State of Maryland was found to have an unexpected number of young physicians starting practice in the smaller cities rather than in the suburbs and cities.[1]

TABLE 4

PRIMARY-CARE PHYSICIANS
ACCORDING TO SIZE OF COMMUNITY
IN MARYLAND 1950-1960

Community Size	1950	1960	Difference	Per Cent Change
0 - 999	202	142	– 60	– 30%
1,000 - 2,499	106	103	– 3	– 2.8%
2,500 - 4,599	74	55	– 19	– 25%
5,000 - 9,999	40	44	+ 4	+10%
10,000 - 24,999	48	44	– 4	– 8.3%
25,000 - >	171	163	– 8	– 4.7%
Baltimore city	976	397	– 579	– 59%

The Anticipated Effect of Retirement Upon the Availability of Physicians to Children

Table 5 shows that between 12% and 17% of the physicians in communities under 5,000 population are over 65. This gives a fairly consistent picture with previous studies in which the average age of general practitioners is higher than other specialists; general practitioners are more likely to be located in smaller communities and young physicians are unlikely to seek practice situations in communities under 5,000 in population.

TABLE 5

PER CENT OF PHYSICIANS
OVER 65 YEARS OF AGE
BY SIZE OF COMMUNITY

Community Size	Per Cent of Physicians Over 65 Years of Age
0 - 999	15%
1,000 - 2,499	12%
2,500 - 4,599	17%
5,000 - 9,999	7%
10,000 - 24,999	4%
25,000 - >	8%

Changes in the Ratios of Primary-Care Physicians to Children by Geographic Area

Figure III shows that in 1940, counties with the largest number of children per primary-care physicians were the rural counties of Carroll, Calvert, Charles, Garrett and St. Mary's. Figure IV shows that in 1960 the counties with the greatest number of children per primary-care physicians were: Baltimore County (surrounding Baltimore city), Prince George's County (the fast-growing suburban area east of the District of Columbia), Howard County (between the two cities), Anne Arundel, Calvert, Charles, and Queen Anne counties. Population increases in the suburban counties have not been accompanied by comparable increases of primary-care physicians.

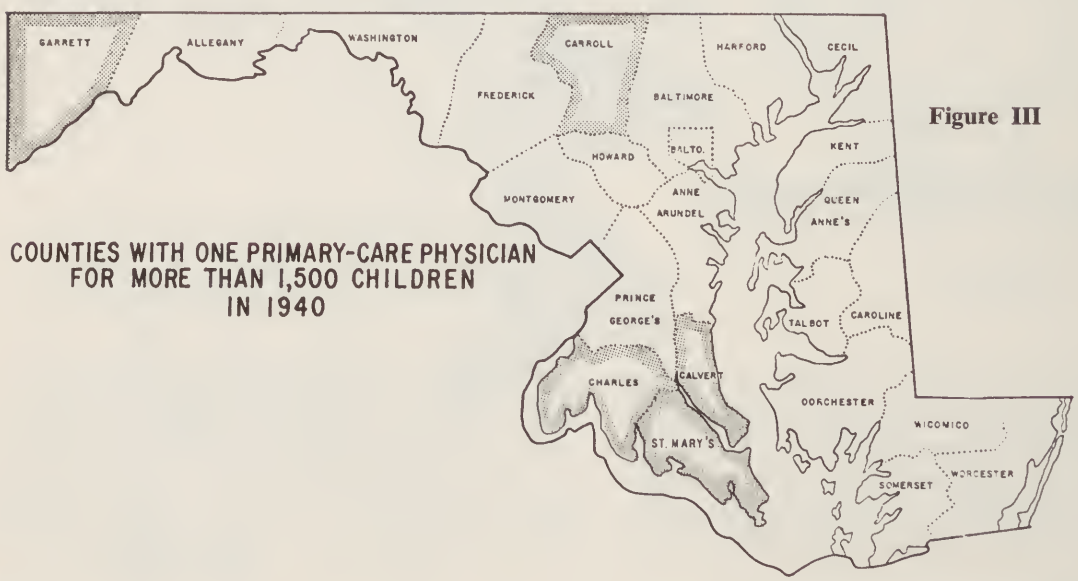


Figure III

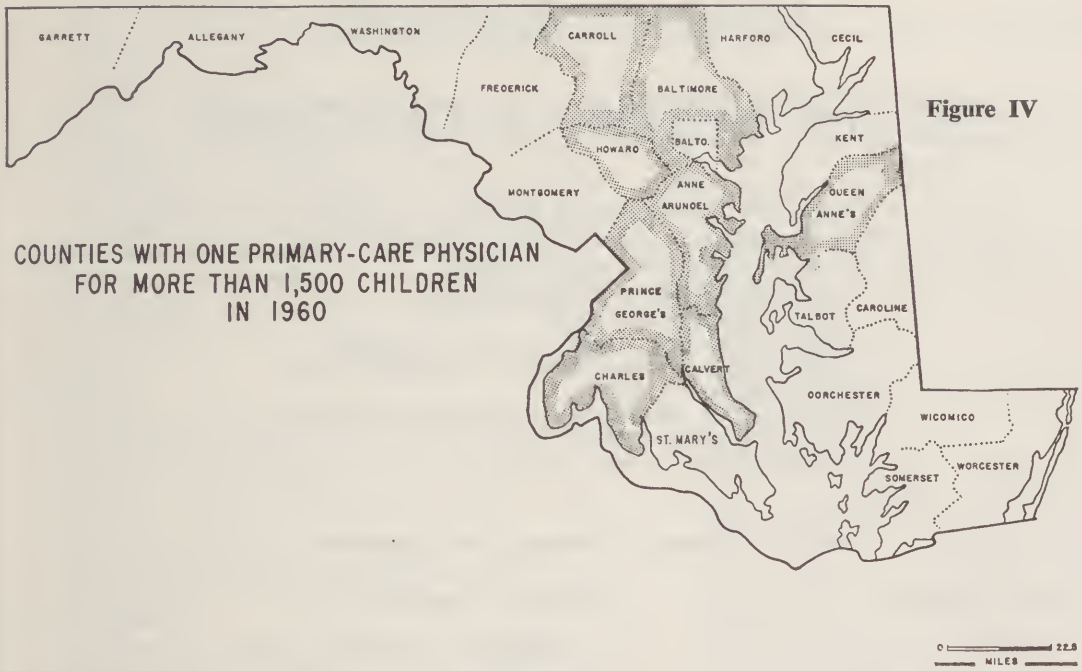


Figure IV

Discussion and Conclusions

To study problems in distribution of pediatricians and general practitioners in relation to the population of children we compared census information from 1940, 1950, and 1960 with the geographic registration of physicians by specialties in 1940, 1950, and 1967. County populations more than doubled between 1940 and 1960 for those counties surrounding Baltimore and the District of Columbia. Eastern Shore counties and the western mountain counties grew at lesser rates and even decreased in two of the counties. The number of general practitioners decreased markedly in number in small communities under 5,000 in population and in the City of Baltimore. The net effects of the rapidly growing population in the suburban counties, the lack of change in rural counties, and the combined numbers of pediatricians and general practitioners is described by ratios of primary-care physicians to children, which show that the suburban populations now experience the same physician to child ratio that some rural counties experienced in 1940. A 12% improvement in the ratio of pediatricians to children was more than offset by the decline of 1 general practitioner for every 430 children to 1 general practitioner for every 1,490 children. This calls attention to the distinct possibility that the rapidly growing suburban counties already have insufficient primary-care physicians for children due to rapidly decreasing numbers of general practitioners and the relatively constant output of pediatricians. Prince George's County, Anne Arundel County, and Baltimore County seem to be particularly susceptible to these trends.

Planning by physicians in these counties is urgent if we desire to have preferred forms of health services for children rather than having undesired alternatives forced upon us. Re-evaluation of these ratios with 1970 census data will be particularly important to determine whether or not these trends have continued. The ratio of 1 primary-care physician to 1,500 children may be an indicator of where we should study the satisfaction or dissatisfaction of families with the present availability of care for their children. To deal with these trends we should also study how primary-care-physician time may be used most efficiently in suburban areas.

REFERENCES

1. Stine, Oscar C.: Changes in the Supply of Physicians Giving Office Medical Care to Children. *Md State Med Jrl* **17**:66-69, January, 1968.
2. U.S. Bureau of the Census, U. S. Census of Population. Characteristics of Population, Maryland. U. S. Government Printing Office, Washington, D.C. 1942, 1963.
3. Stewart, William A., Pennell, Marilyn Y.: Pediatric Manpower in the United States and Its Implications. *Ped* **32**:311-318, February 1963.
4. Bergman, Abraham B., Haggerty, Robert J.: The Emergency Clinic. *Am J of Dis of Children* **104**:36-44, 1962.
5. American Medical Association: Geographic Register of Physicians. **16**:1940, **21**:1961.
6. Somers, Anne R.: Some Basic Determinants of Medical Care and Health Policy, in: Kissick, William L., Dimensions and Determinants of Health Policy, *Milbank Memorial Fund Quarterly* **46**:12, 1968.

ANNUAL REPORTS

TO THE HOUSE OF DELEGATES

Mr. President and Members of the House of Delegates:

The following committees held no meetings during the year and have no reports to make:

Committee on Contractual Arrangements
Medical Annals of Maryland
Medical Emergency Disaster Service Committee
Membership Committee (abolished, Semiannual Meeting, September 5, 1969)
Committee on Medicine and Religion (full committee, Annual Meeting, 1969)
Student American Medical Association

Index to Reports of Officers and Committees

Board of Medical Examiners 62
Bylaws 58
Council and Executive Committee 56
Curator 63
Delegates to the AMA 64
Emotional Health 64
Executive Secretary 57
Finance 65
Legislative 65
Liaison 66
Library and History, Finney Fund 66
Maryland Medical Political Action 67
Maryland Medical Service, Inc. Board of Directors 68
Maryland State Medical Journal 69
Med-Chi Insurance Trust 69
Mediation 70
Medical Economics 72
Medical Tissue Donation 72
Medicolegal 72
Nominating 73
Occupational and Environmental Health 73
Policy and Planning 74
Postgraduate Education, Preventive Medicine and Public Health 74
Professional Medical Services 77
Program and Arrangements 78
Public Relations 78
Reference 79
Secretary 57
Special Committees 80
Treasurer 81
Woman's Auxiliary 96

COUNCIL AND EXECUTIVE COMMITTEE

Mr. President and Members of the House of Delegates:

The Council and Executive Committee held regular sessions during the past year including one immediately preceding and one immediately following the House of Delegates sessions at the 1970 Annual Meeting.

Summaries of all Council and Executive Committee sessions are published in the *Maryland State Medical Journal* each month in order to apprise the membership of our activities.

In addition to making recommendations for Emeritus Membership at the Annual and Semiannual sessions and referring other matters to the House, the following policy decisions were made by your designated representatives authorized to conduct Faculty business between House meetings:

- Discussed with Social Security medical officials various health programs and health screening projects conducted at Woodlawn;
- Endorsed a tuberculosis screening project proposed by the Maryland Tuberculosis Association;
- Authorized Faculty representatives to attend meetings in Chicago regarding the proposed revised JCAH standards;
- Authorized appointment of various ad hoc committees (the reports of these committees appear in this compilation of reports under the heading "Special Committees");
- Submitted nominees for appointment to various gubernatorial, state agency, public agency, voluntary agency, etc. positions;

- Approved a proposal to establish a preschool Hearing and Vision Screening Survey under Faculty auspices with the cooperation of other interested groups;
- Authorized legal counsel to file Amicus Curiae briefs in Court of Appeals cases regarding: (a) testimony of a chiropractor in court and disallowance of such testimony, and (b) use of material in obtaining a court conviction of a patient, such material having been provided a physician during the course of treatment;
- Adopted a report dealing with policy on admission of patients to intensive and coronary care units in hospitals;
- Agreed to form an Advisory Committee on Human Trials;
- Agreed to conduct an in-depth study of physician manpower in cooperation with the Department of Health and Mental Hygiene;
- Adopted a report on the Revised Policy on Laboratory Services;
- Authorized renewal of the contract of the Executive Secretary for an additional three-year period on the same terms and conditions as previously accepted;
- Adopted the following amended recommendation of the Ad Hoc Committee to Discuss Multiphasic Screening Programs:

"The Ad Hoc Committee to Discuss Multiphasic Screening Programs concurs with the feasibility report submitted by the Bendix Corporation and recommends its acceptance. It further believes that this concept is worthwhile, even though still in its infant stage and that lines of communication should be kept open with the Bendix Corporation or other groups so that implementation could take place in the event changes occur in our social and environmental setting.

"The Committee also recommends that the Faculty go on record as being interested in instituting such a program under Faculty sponsorship, in the event it does become feasible. The Committee recommends that this subject should be reconsidered at regular six-month periods."

- Adopted the following recommendations of the Mediation Committee with the understanding that this data was to be forwarded to the Drug Abuse Authority when it became effective on July 1, 1969:

"That the Medical and Chirurgical Faculty of Maryland endorses the concept that selected hospitals be encouraged to establish drug abuse treatment centers under their auspices either as part of, or at some reasonable proximity to its hospital facilities under strict professional and administrative controls, and using accepted methods of treatment and ancillary personnel, such as medical social workers, psychologists, nutritionists, etc., as well as psychiatrists, internists, pediatricians, etc.

"It is understood that such selected hospitals must have adequate staffing, resources, financing, space and other facilities and that they would conform with the Ethical Guidelines for the Treatment of Narcotic Addicts, as adopted by the Medical and Chirurgical Faculty."

- Adopted the following policy statement on sex education and family life planning, as amended, after considerable discussion and debate. Karl M. Green, MD, chairman of the Faculty's Subcommittee on Child Welfare of the Committee on Postgraduate Education, Preventive Medicine and Public Health, joined the Council to discuss this proposal:

"The Medical and Chirurgical Faculty of the State of Maryland recognizes that the primary responsibility for sex education will always remain within the home, but the school, church, and some other community agencies have a supplementary role in reinforcing and supporting the efforts of the home.

"The Faculty supports the inauguration and implementation within the school system of a family life and sex education program which will fill the following criteria:

1. That it be part of an overall health education and biology program
2. That it be presented in a manner commensurate with the maturity and emotional level of the students
3. That the sex education course follow a professionally developed and regulated curriculum
4. That the sex education program attempt to involve parents and other members of the community within the classroom teaching situation
5. That the sex education program utilize classroom teachers and other professionals and subprofessionals who have shown an aptitude for working with young people and who have received special training
6. That the sex education program prior to presentation have as consultants, advisors and resource persons: physicians, nurses, and public health personnel, who are responsible for the *development* and guidance of such a curriculum and that the medical societies (both state and components) be encouraged to take an active part."

Respectfully submitted,
JOHN F. SCHAEFER, MD, *Chairman*

SECRETARY

Mr. President and Members of the House of Delegates:

The majority of the work of the Faculty is conducted within committees and the activity resulting from such work is carried out by the various members of the Faculty staff.

The ultimate responsibility for the efficient operation of the Faculty, however, rests with the Secretary who is your elected officer. In this capacity, he serves as an ex-officio member of all committees and subcommittees.

Complete data on committee and other activity of the Faculty is available at the Faculty's headquarters.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, *Secretary*

EXECUTIVE SECRETARY

Mr. President and Members of the House of Delegates:

On April 15, 1970 I completed 12 years of service with the Faculty. These years have been rewarding for me and, I hope, as equally rewarding for the Faculty and its members.

I believe the Faculty continues to make progress in all fields of endeavor.

While the major role in completion of various projects for the benefit of the public and the profession remains with the various committees and members, I like to feel that I play a small part in accomplishing these goals.

Respectfully submitted,
JOHN SARGEANT, *Executive Secretary*

BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

Your Bylaws Committee met on Wednesday, February 4, 1970 to discuss with representatives of the Baltimore City Dental Society and the Maryland State Dental Association the inclusion of members of these organizations on various Faculty Committees.

It was the consensus of the entire group that it would be more preferable to have Faculty Bylaws provide for membership on the following Committees as a representative of the Maryland State Dental Association, rather than the Baltimore City Dental Society as presently written:

Medical Economics Committee
Legislative Committee
Library and History Committee
Professional Medical Services Committee
Program and Arrangements Committee
Public Relations Committee

It was also agreed that no useful purpose was served in having representation of the State Dental Association on the Faculty's Mediation Committee.

Accordingly, the following Bylaw Amendments are offered to the House of Delegates for its consideration:

Amend Article XI, Sections 3, 8, 10, 19, 21 and 22 by striking out "Baltimore City Dental Society" and inserting "Maryland State Dental Association".

OLD (Bracket portion deleted)	NEW (CAPS added)
Section 3. A MEDICAL ECONOMICS COMMITTEE of at least five members shall serve as a Review Committee for health insurance and other third party payors to determine equitable and just fees for procedures performed and for which such carriers are responsible. It may only act on the request of the carrier or patient or physician involved, and after the medical service has been rendered. It shall not determine the legal rights or benefits under such policies. It shall also be empowered to investigate, within the responsibilities and charges designated in these bylaws, areas of economic benefits for members of the Faculty. It shall receive the report of the Faculty's officially approved Professional Liability Program and shall prepare and present an educational program to physicians in this regard. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the Committee with the approval of the President. The (Baltimore City Dental Society) shall have the right to elect one associate member of the Committee with voice but no vote.	Section 3. A MEDICAL ECONOMICS COMMITTEE of at least five members shall serve as a Review Committee for health insurance and other third party payors to determine equitable and just fees for procedures performed and for which such carriers are responsible. It may only act on the request of the carrier or patient or physician involved, and after the medical service has been rendered. It shall not determine the legal rights or benefits under such policies. It shall also be empowered to investigate, within the responsibilities and charges designated in these bylaws, areas of economic benefits for members of the Faculty. It shall receive the report of the Faculty's officially approved Professional Liability Program and shall prepare and present an educational program to physicians in this regard. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the Committee with the approval of the President. The MARYLAND STATE DENTAL ASSOCIATION shall have the right to elect one associate member of the Committee with voice but no vote.
Section 8. A LEGISLATIVE COMMITTEE composed of at least five members appointed by the President shall inform itself on all legislation, national, state and local, affecting the practice of medicine; advise the Faculty when necessary in regard to such legislation; and, with the President or such other person as the Council or House of Delegates may name, represent the Faculty before any legislative body when required. The President shall designate the chairman. (The Baltimore City Dental Society) shall have the right to elect one associate member of the committee with voice but without vote. The President shall request each component society annually to appoint a representative to meet with the committee on a consulting basis at the request of the chairman of the committee.	Section 8. A LEGISLATIVE COMMITTEE composed of at least five members appointed by the President shall inform itself on all legislation, national, state and local, affecting the practice of medicine; advise the Faculty when necessary in regard to such legislation; and, with the President or such other person as the Council or House of Delegates may name, represent the Faculty before any legislative body when required. The President shall designate the chairman. The MARYLAND STATE DENTAL ASSOCIATION shall have the right to elect one associate member of the committee with voice but without vote. The President shall request each component society annually to appoint a representative to meet with the committee on a consulting basis at the request of the chairman of the committee.
Section 10. A LIBRARY AND HISTORY COMMITTEE of five members, one of whom shall be elected at the annual session of the House of Delegates each year for a five-year term, shall have the control and supervision of all books, pamphlets, periodicals and written or printed material, including historical material, belonging to the Faculty; shall have authority to order and purchase such additions or replacements as it deems necessary within its budget, and shall prepare and maintain historical records regarding the Faculty and each Faculty Fund. The (Baltimore City Dental Society) shall have the right to elect one associate member of the committee. It shall elect its own chairman.	Section 10. A LIBRARY AND HISTORY COMMITTEE of five members, one of whom shall be elected at the annual session of the House of Delegates each year for a five-year term, shall have the control and supervision of all books, pamphlets, periodicals and written or printed material, including historical material, belonging to the Faculty; shall have authority to order and purchase such additions or replacements as it deems necessary within its budget, and shall prepare and maintain historical records regarding the Faculty and each Faculty Fund. The MARYLAND STATE DENTAL ASSOCIATION shall have the right to elect one associate member of the committee. It shall elect its own chairman.

Section 19. A PROFESSIONAL MEDICAL SERVICES COMMITTEE shall consider and advise the Faculty on all matters relating to the professional services provided to the public by members of the Faculty. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. It shall make available facts, data and opinions with respect to timely and adequate rendition of medical care to the public; to investigate matters pertaining to the economics of medical practice and where related, social aspects of medical care; it shall study means for the distribution of medical service to the public consistent with the principles adopted by the Faculty's House of Delegates and the AMA's House of Delegates. It shall be composed of (1) a chairman appointed by the President, (2) five members of the Faculty selected by the President, (3) one general practitioner from each councilor district selected by the President from among a group composed of one nominee elected by each component society and (4) one representative selected by each state-wide specialty group which desires representation. The (Baltimore City Dental Society) shall have the right to elect one associate member of the committee with voice but without vote.

Section 19. A PROFESSIONAL MEDICAL SERVICES COMMITTEE shall consider and advise the Faculty on all matters relating to the professional services provided to the public by members of the Faculty. It shall not conflict in any way with charges made in these bylaws to other committees of the Faculty. It shall make available facts, data and opinions with respect to timely and adequate rendition of medical care to the public; to investigate matters pertaining to the economics of medical practice and where related, social aspects of medical care; it shall study means for the distribution of medical service to the public consistent with the principles adopted by the Faculty's House of Delegates and the AMA's House of Delegates. It shall be composed of (1) a chairman appointed by the President, (2) five members of the Faculty selected by the President, (3) one general practitioner from each councilor district selected by the President from among a group composed of one nominee elected by each component society and (4) one representative selected by each state-wide specialty group which desires representation. The MARYLAND STATE DENTAL ASSOCIATION shall have the right to elect one associate member of the committee with voice but without vote.

Section 21. A COMMITTEE ON PROGRAM AND ARRANGEMENTS of four members, one of whom shall be elected at the annual session of the House of Delegates each year for a four-year term, shall prepare and issue a program for General Meetings, provide suitable accommodations for the meetings of the Faculty and have charge of all arrangements. The member whose term next expires shall be chairman. The (Baltimore City Dental Society) shall have the right to elect one associate member of the committee with voice but without vote.

Section 21. A COMMITTEE ON PROGRAM AND ARRANGEMENTS of four members, one of whom shall be elected at the annual session of the House of Delegates each year for a four-year term, shall prepare and issue a program for General Meetings, provide suitable accommodations for the meetings of the Faculty and have charge of all arrangements. The member whose term next expires shall be chairman. The MARYLAND STATE DENTAL ASSOCIATION shall have the right to elect one associate member of the committee with voice but without vote.

Section 22. A PUBLIC RELATIONS COMMITTEE of at least five members shall undertake to supply speakers to organizations requesting them on subjects relating to the practice of medicine; undertake such methods as it deems advisable to inform and instruct the public generally on subjects related to the practice of medicine; issue to the press and other media of public information releases relating to the meetings, actions and activities of the Faculty, with the advice and approval of the President or Executive Secretary, and serve in an advisory capacity to the Woman's Auxiliary. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President. The (Baltimore City Dental Society) shall have the right to elect one associate member of the committee with voice but without vote.

Section 22. A PUBLIC RELATIONS COMMITTEE of at least five members shall undertake to supply speakers to organizations requesting them on subjects relating to the practice of medicine; undertake such methods as it deems advisable to inform and instruct the public generally on subjects related to the practice of medicine; issue to the press and other media of public information releases relating to the meetings, actions and activities of the Faculty, with the advice and approval of the President or Executive Secretary, and serve in an advisory capacity to the Woman's Auxiliary. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President. The MARYLAND STATE DENTAL ASSOCIATION shall have the right to elect one associate member of the committee with voice but without vote.

Amend Article XI, Section 11 by striking out the last sentence thereof:

"The Baltimore City Dental Society shall have the right to elect one associate member of the Committee with voice but without vote in all committee deliberations except those relating to grievances or complaints."

OLD

(Bracket portion deleted)

Section 11. A MEDIATION COMMITTEE composed of the five most recent living Immediate Past Presidents, not serving on the Commission on Medical Discipline and at least five additional members appointed by the President shall hear and determine all grievances or complaints and formulate guidelines involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President. (The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all committee deliberations except those relating to grievances or complaints.)

NEW

(CAPS added)

Section 11. A MEDIATION COMMITTEE composed of the five most recent living Immediate Past Presidents, not serving on the Commission on Medical Discipline and at least five additional members appointed by the President shall hear and determine all grievances or complaints and formulate guidelines involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President.

Amend Article II, Section 2, Subsection (a) (6) by striking out "Society" and inserting "Association":

OLD

(Bracket portion deleted)

Section 2. (a) ASSOCIATE MEMBERS shall consist of all associate members of all component societies who are (1) Doctors of Medicine who are not engaged in the full-time practice of medicine; (2) Doctors of Medicine engaged in the practice of medicine and in full-time positions in a medical school, having a rank below that of associate professor; (3) Doctors of Medicine on the resident staff of a hospital, or holding a fellowship, and not in private practice; (4) persons holding academic degrees equivalent to the degree of Doctor of Medicine devoting their full-time to the study and teaching of the medicine sciences, the determination that the degree is equivalent being made in each case by the component society; (5) commissioned medical officers of the armed forces, public health service and Veterans Administration; (6) members of the Maryland State Dental (Society) in good standing with that Society, other than those outlined in (5) preceding; and (7) members of the Baltimore City Dental Society in good standing with that society.

NEW

(CAPS added)

Section 2. (a) ASSOCIATE MEMBERS shall consist of all associate members of all component societies who are (1) Doctors of Medicine who are not engaged in the full-time practice of medicine; (2) Doctors of Medicine engaged in the practice of medicine and in full-time positions in a medical school, having a rank below that of associate professor; (3) Doctors of Medicine on the resident staff of a hospital, or holding a fellowship, and not in private practice; (4) persons holding academic degrees equivalent to the degree of Doctor of Medicine devoting their full-time to the study and teaching of the medicine sciences, the determination that the degree is equivalent being made in each case by the component society; (5) commissioned medical officers of the armed forces, public health service and Veterans Administration; (6) members of the Maryland State Dental ASSOCIATION in good standing with that Society, other than those outlined in (5) preceding; and (7) members of the Baltimore City Dental Society in good standing with that society.

No changes are offered in Article II, Section 2 of the Bylaws dealing with membership classifications, as associate membership is already available to members of the Maryland State Dental Association. Members of the Baltimore City Dental Society are required to be members of the State Dental Association and such membership is directly from the local Dental component to the Faculty. When and if members of the State Dental Association wish to become members of the Faculty, application would be made directly to the Faculty.

In a previous meeting on October 15, 1969, the following Bylaw changes were also discussed and are also offered to the House of Delegates for its consideration:

1. Change title of Executive Secretary to Executive Director.

Article VI, Section 4:

OLD

(Bracket portion deleted)

Section 4. All resolutions involving questions of Faculty policy which will be presented to the House of Delegates for action shall be filed with the Executive (Secretary)....

NEW

(CAPS added)

Section 4. All resolutions involving questions of Faculty policy which will be presented to the House of Delegates for action shall be filed with the Executive DIRECTOR....

Article VII, Section 5:

OLD

(Bracket portion deleted)

Section 5. The Council shall employ under contract an EXECUTIVE (SECRETARY)...

NEW

(CAPS added)

Section 5. The Council shall employ under contract an EXECUTIVE DIRECTOR...

2. Change provision for transfer of members from one Component Society to another.

Article I, Sections 4 and 5:

OLD

(Bracket portions deleted)

Section 4. Component societies shall be the judges of the qualifications of their own members, provided that they may admit to membership every reputable and legally registered doctor of medicine who does not practice, claim to practice or support any exclusive system of medicine and who (1) is not a member of another component society, and (2) maintains his principal office within its area, or (3) maintains his residence within its area and the society in whose area he maintains his principal office consents. If a physician also maintains an office in the area in which he resides, he may choose to apply for membership in either the component society in whose area he resides or has his principal office. If, due to moving either his office or residence, a physician becomes ineligible to continue his membership in a component society, his membership must be transferred to the appropriate component society within sixty days.

NEW

(CAPS added)

Section 4. Component societies shall be the judges of the qualifications of their own members, provided that they may admit to membership every reputable and legally registered doctor of medicine who does not practice, claim to practice or support any exclusive system of medicine and who (1) is not a member of another component society, and (2) maintains his principal office within its area, or (3) maintains his residence within its area and the society in whose area he maintains his principal office consents. If a physician also maintains an office in the area in which he resides, he may choose to apply for membership in either the component society in whose area he resides or has his principal office. If, due to moving either his office or residence, a physician becomes ineligible to continue his membership in a component society, his membership must be transferred to the appropriate component society within sixty days UNLESS MUTUALLY AGREEABLE TO BOTH COMPONENT SOCIETIES TO WAIVE THIS REQUIREMENT.

OLD	NEW
Section 5. Component societies shall transfer the membership of any member upon request without cost to another component society in which the member's application has been accepted provided the member is in good standing.	Section 5. Component societies shall transfer the membership of any member upon request without cost to another component society in which the member's application has been accepted provided the member is in good standing. MEMBERS WHO APPLY FOR TRANSFER SHALL REMAIN MEMBERS IN GOOD STANDING OF THE COMPONENT SOCIETY FROM WHICH THEY REQUEST TRANSFER UNTIL SUCH TIME AS THEIR TRANSFER IS ACTED UPON EITHER ACCEPTING OR REJECTING SUCH TRANSFER OF MEMBERSHIP.

3. Amend Article XIV by adding new Section 12 as follows:

OLD	NEW
(Bracket portions deleted)	(CAPS added)
(None)	Section 12. NOTWITHSTANDING THE ABOVE PROVISIONS OF THIS ARTICLE, ANY MEMBER OF THE FACULTY WHOSE LICENSE TO PRACTICE MEDICINE AND SURGERY IS SUSPENDED OR REVOKED BY AN ORDER OF THE COMMISSION ON MEDICAL DISCIPLINE WHICH HAS BECOME FINAL PURSUANT TO THE LAW SHALL SUFFER SUSPENSION OR EXPULSION, RESPECTIVELY, OF FACULTY MEMBERSHIP FOR THE SAME PERIOD OF TIME AND UPON THE SAME CONDITIONS AS CONTAINED IN THE COMMISSION'S ORDER. THE PROVISIONS OF THIS SECTION SHALL BE SELF-EXECUTING AND SHALL TAKE EFFECT AT THE TIME THE COMMISSION'S ORDER SHALL BECOME FINAL.

The Bylaws Committee also recommends the following new Bylaw which will create formal recognition of a Committee on Peer Review. This is in line with a request from the American Medical Association's House of Delegates; as well as the various third party and governmental agencies involved in the payment of medical care.

Amend Article XI, by inserting after Section 16, the following new section (all remaining sections being automatically renumbered); provided that the initial appointments to the Committee shall decide by lot the lengths of their initial terms:

OLD	NEW
(None)	(CAPS added)
	THE PRESIDENT SHALL APPOINT A PEER REVIEW COMMITTEE OF NINE MEMBERS, THREE OF WHOM SHALL BE APPOINTED ANNUALLY FOR THREE-YEAR TERMS. IT SHALL BE THE DUTY OF THIS COMMITTEE TO ADVISE THIRD PARTY AND OTHER AGENCIES AS TO THE APPROPRIATENESS OF MEDICAL CARE RENDERED BY MARYLAND PHYSICIANS IN INSTITUTIONS AND OFFICES OR OTHER LOCATIONS WHERE HEALTH CARE IS RENDERED. IT SHALL DEVELOP SUITABLE CRITERIA TO ADEQUATELY EVALUATE THE INDIVIDUAL AND COLLECTIVE VOLUME, COST AND QUALITY OF MEDICAL CARE WHEREVER PROVIDED. THE COMMITTEE SHALL STIMULATE AREA HOSPITALS' MEDICAL STAFFS TO DEVELOP APPROPRIATE MECHANISMS SUCH AS UTILIZATION COMMITTEES FOR REVIEW OF HOSPITAL ADMISSIONS WITH RESPECT TO NEED FOR ADMISSION, LENGTHS OF STAY, DISCHARGE PRACTICES AND EVALUATION OF SERVICES ORDERED AND PROVIDED. THE CHAIRMAN SHALL BE DESIGNATED ANNUALLY BY THE PRESIDENT.

Respectfully submitted,

Charles F. O'Donnell, MD, *Chairman*
Arthur E. Cocco, MD
DeWitt E. DeLawter, MD
Vincent J. Fiocco, Jr., MD

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

The Board of Medical Examiners is composed of the following members whose terms expire on the dates indicated below:

Elmer G. Linhardt, MD 1970
William L. Stewart, MD 1970
J. Roy Guyther, MD 1971
Gerald A. Galvin, MD 1971
Karl F. Mech, MD 1972
Archie R. Cohen, MD 1972
John E. Adams, MD 1973
DeWitt E. DeLawter, MD 1973

As the terms of Elmer G. Linhardt, MD, and William L. Stewart, MD, expire June 1970, two members to serve until 1974 are to be elected at the meeting of the Medical and Chirurgical Faculty.

Examinations given during the year show the following results:

Applications received for examination		557
Second year students examined and reexamined		61
Postponed, withdrawn or did not appear		106
Failed to complete		1
Not eligible for license		168
Examined in second part of examination		50
Complete examination		204
Reexamined		135
Eligible for license		389
Passed—American Graduates	87	
Passed—Foreign Graduates	113	
Failed—American Graduates	34	
Failed—Foreign Graduates	155	

American Graduates who failed are as follows:

Univ. Colorado—1; Howard Univ.—21; Meharry Med. Col.—2; Women's Col. of Pa.—2; Univ. Puerto Rico—2; Univ. Washington—1; Univ. West Virginia—1; Johns Hopkins Univ.—1; Univ. Maryland—3.

Licenses issued after examination	200
Licenses issued by endorsement of National Board Certificate	344
Licenses issued by reciprocity with other State Licenses	203
Total licenses issued	747
Licenses revoked	0
Licenses suspended	1
Licentiates certified to other states	366
Copies of licenses issued	15
American graduates examined and reexamined	182
Foreign graduates examined and reexamined	388
Foreign graduates approved for examination	448
Written inquiries from foreign graduates (approximately)	800
Office interviews from foreign graduates (approximately)	400
Telephone inquiries from foreign graduates (approximately)	1,500
Telephone inquiries concerning registration of physicians	3,000
Registration certificates issued from 1/1/69 to 12/31/69	4,989

Licensed by Special Examination

Palem S. Rao, MD—December 18, 1969

Suspension of Medical License

On June 30, 1969, the license of *Alfred J. Cole, MD,* was suspended for 60 days for failure to prepare, obtain and keep complete and accurate records of certain depressant and stimulant drugs as required by federal law.

On April 24, 1969, the suspension of the license of *Miller Maurice Ryans, MD,* was terminated.

Reprimands

Carlos Alvarado, MD, appeared before the Executive Committee on December 20, 1968, with regard to his practicing as an unlicensed physician. Dr. Alvarado was notified that administrative duties were permissible under the Medical Practice Act. He was further notified that any future violation of the Medical Practice Act would be referred to the proper authority for prosecution.

William Hugh L. Westbrook, Jr., MD, appeared before the Executive Committee on January 16, 1969. It was the decision of the Executive Committee, in view of his limited capacity, that he be permitted to continue in his field of practice under direct supervision.

Oscar B. Camp, MD, and Joseph J. Cameron, MD, appeared before the Executive Committee on January 16, 1969, to discuss their association with the Eastpoint Medical Center with regard to advertising. It was their decision to resign from the Board of Directors of Eastpoint Medical Center and disassociate themselves from the center.

Luis Cuza, MD, appeared before the Executive Committee on January 16, 1969, and gave a satisfactory report of his professional activities. An order from the U.S. District Court, terminating the probation of Dr. Cuza, was presented to the Board for consideration of terminating the Board's probationary period of Dr. Cuza. It was the decision of the Board, on June 3, 1969, to terminate this probation, after first discussing with Dr. Cuza the importance of adhering to the provisions of the law as established by the Commission on Medical Discipline.

William L. Johnson, MD, an unlicensed, unregistered physician in the State of Maryland, has been allegedly circulating literature with regard to activities involving sex power, etc. This has been referred to the State's Attorney for Baltimore city for necessary action.

Marvin A. Jackson, MD, appeared before the Executive Committee on March 13, 1969, with regard to advertising in the *Baltimore Afro-American.* Dr.

Jackson stated he was unaware this advertisement was being run. Dr. Jackson notified the particular laboratory involved, and a copy of the letter was forwarded to the Executive Committee.

Carlos Arrabal, MD. It was the decision of the Executive Committee to terminate the regular reportings of Dr. Arrabal to the Executive Committee. He has been notified that we are available to him at any time for consultation, if he so desires.

Dahmes Gounarnis, MD. The Board was notified that Dahmes Gounarnis was practicing medicine in Maryland without a license, located in a garage behind the office of Harry Deibel, MD. There is nothing in our files to indicate that this individual is a qualified doctor of medicine. The matter was referred to the State's Attorney's office and the Attorney General's office for investigation and action. A letter was received from Harry Deibel, MD, stating that his association with Dr. Gounarnis was severed as of June 27, 1969.

Clinton Community Hospital, Inc. A letter was received from Dr. Merkle, Director of Clinton Community Hospital, Inc. regarding the employment of unlicensed physicians. It was the decision of the Board to notify Dr. Merkle that these physicians are in violation of the Medical Practice Act in view of the fact that they do not possess a Maryland medical license and do not qualify in an approved training program, citing Article 43, Sections 130, 131, and 139 of the Annotated Code of Public General Laws of Maryland, 1957 Edition, 1968 Supplement.

Cases being referred to the Medical and Chirurgical Faculty—Commission on Medical Discipline

Under Article 43, Section 145, the following cases have been referred to the Medical and Chirurgical Faculty for investigation or referral to the Commission on Medical Discipline or both:

G. R. Sadjadi, MD	G. Franklin Phillips, MD
George H. Beck, MD	E. A. Purnell, MD
Milton J. Wohl, MD	Milan M. Vuitch, MD
Joshua Mitchell, MD	Morris A. Jacobs, MD
John F. Coolahan, MD	Charles J. Savarese, MD
Harry L. Hinson, MD	Wilfred H. Ehrmantraut, MD
Barnett Rhetta, MD	

Surrender of Medical License

John Gordon Rennie, MD. It was the decision of the Board to hold a hearing for consideration of revocation or suspension of Dr. Rennie's license in August, 1969. Dr. Rennie notified the Board that he would voluntarily surrender his license to practice medicine in Maryland. It was the decision of the Board to accept voluntary surrender of Dr. Rennie's license. This license was received on May 16, 1969.

Archie C. Lewis, MD, has voluntarily surrendered his license to practice medicine in the State of Maryland, as of October 2, 1969.

Elizabeth Reese Wilkens, MD, has voluntarily surrendered her license to practice medicine in the State of Maryland, as of October 7, 1968. She has notified this office that she is unable to locate the actual document. She is now residing at Horton's Boarding Home, Union Bridge, Maryland.

Robert M. Hening, MD, has voluntarily surrendered his license to practice medicine in the State of Maryland, as of October 28, 1969.

Commission on Medical Discipline

The following Board members were elected to serve on the Commission on Medical Discipline: Archie R. Cohen, MD, Elmer G. Linhardt, MD, and Karl F. Mech, MD.

Leonard H. Flax, MD

A letter dated July 22, 1969, from Dr. Flax was received in which he requested information relative to giving refresher courses to physicians being re-examined by the Board. Dr. Flax was notified that it is the present policy of the Board not to approve refresher courses to be given by individual physicians, but only those of an official educational institution. Grades obtained by examinees are not furnished to anyone other than the examinee or officially recognized licensing Boards of other states.

Filing of Board Rules and Regulations

In accordance with Chapter 797 of the Laws of Maryland, effective July 1, 1969, current rules and regulations of the Board of Medical Examiners were filed with the appropriate state agencies.

Maryland Tuberculosis Association, Inc.

A letter was received from the Maryland Tuberculosis Association, Inc. inquiring as to what level of personnel would legally be required for administering and measuring tuberculin tests. The association was notified to the effect: "A discussion of the procedures that could be performed by registered nurses, with a licensed physician taking full responsibility, resulted in the following suggestions provided by the Maryland Nurses Association and adopted by the Council of the Medical and Chirurgical Faculty on June 17, 1965. To wit: Generally, if the act performed by the registered nurse is basically mechanical, not requiring the exercise of medical judgment, and is done by order of or supervision by a physician, it is legal. In regard to the nurse interpreting the test, this would be contrary to the Medical Practice Act."

Sixty-Fifth Annual Congress on Medical Education and Licensure

Doctors Karl F. Mech, Vernon H. Norwood and Elmer G. Linhardt attended the congress held in Chicago, Illinois, February 7-10, 1969.

Respectfully submitted,
ELMER G. LINHARDT, MD, *Executive Secretary*

CURATOR

Mr. President and Members of the House of Delegates:

Material of historic interest to the profession and the Faculty continues to flow into the Faculty offices and we are most grateful that an appropriate repository exists for this data.

Items received during the past year include:

Surgical instruments owned by William E. Woodall, an employee of the Baltimore City Health Department from about 1888 to 1936. They were used by him to release accumulated gas from abandoned cadavers of smallpox victims "around the turn of the century." These were a gift of his nephew, Mr. Denwood N. Kelly, of Baltimore.

(These items, along with others in our collection, have been placed on permanent loan to the Carroll County Medical Society for its Farm Museum.)

From Louis A. M. Krause, MD, of Baltimore:

Studies in Rabies, a testimonial volume, 1909, by Nathaniel Garland Kierle, LLD;
Sphygmomanometer; speculums; skull; assorted instruments

From an anonymous donor, a relative of Solomon C. Katzoff, MD, 1879-1968:

6 ampules of sterile water, 5 cc in size; glass mortar and pestle; stethoscope; nickel container with hypodermic syringe, 2 needles and 6 empty glass vials; obstetrical forceps; leather case containing small instruments; metal box containing "improved prescription scale": (The D.C.H. Fitch); metal box containing "improved antitoxin syringe" by K. K. Mulford Co., of Philadelphia; 10 miscellaneous instruments.

The Faculty also received, through the kindness of Raymond C. Markley, MD, of Baltimore, the following material from Mrs. Charlotte White:

Assorted instruments and a cardboard box of needle tubes which belonged to her husband, William Kelso White, MD.

(Dr. Markley requested these be retained by him on permanent loan for use at University of Maryland Hospital, and for display in his private office.)

In each case, the donor of the gift, when known, has been suitably thanked and the item has been recorded in the accession records of the Faculty.

During the year, the Faculty had on display in the Pratt Library window on Cathedral Street in Baltimore, a medicine chest owned by Robert Moore, MD, 1764-1844. This was in honor of Doctors' Day in 1969, sponsored by the Woman's Auxiliary to the Baltimore City Medical Society, with credit given to the Faculty.

As has been authorized and carried out each year, the sum of $500 has been expended for restoration and care of the large portrait collection belonging to the Faculty and exhibited in its headquarters.

Respectfully submitted,
E. David Weinberg, MD, *Curator*

DELEGATES TO THE AMA HOUSE OF DELEGATES

NOVEMBER 30—DECEMBER 3, 1969 DENVER

Mr. President and Members of the House of Delegates:

Your three delegates and the senior alternate delegate attended the Clinical Meeting of the American Medical Association House of Delegates in Denver, Colorado, November 30 through December 3, 1969. Russell S. Fisher, MD, served as chairman of one of the reference committees reporting to the House, and was an able representative from the Free State of Maryland. The other delegates and alternate delegates attended various Reference Committee hearings, discussed resolutions and reports, and reported to the entire delegation the comments and discussions that took place at these sessions. The delegation also met with numerous Trustees in informal discussions of multiple medical problems.

This meeting was one of the least controversial and most productive held in many years. It was not marked by demonstrations, as was the Annual Session in July 1969, probably because a decision had been made prior to the meeting to quickly and quietly deny the floor to any individuals who demanded the right to speak at any of these sessions.

In addition to the official delegation from the state being present at the House of Delegates sessions, the Executive Secretary attended sessions of the American Association of Medical Society Executives; as well as an all-day Peer Review session in Denver held just prior to the meetings of the House of Delegates.

(A complete report of the transactions may be found in JAMA)

Respectfully submitted,
Robert vL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD
Charles F. O'Donnell, MD, *Senior Alternate*

COMMITTEE ON EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

The Committee on Emotional Health has had monthly meetings during the past year with many current issues considered and recommendations made. At one meeting the State Budget for Mental Health Plans was reviewed and discussed with Alice Tobler, MD, chairman of the State Department of Mental Hygiene committee that studied the Maryland State Comprehensive Plan for Community Mental Health Services, and James E. Carson, MD, Commissioner of Mental Hygiene for Maryland. Included in this discussion were Community Mental Health Services.

At another meeting, Joseph Baker, MD, from the Department of Mental Health of the American Medical Association was present and many matters were discussed from both a national and a local level.

The membership of the committee was divided into groups of two each to study the following specific broad subjects: (1) means of expediting services for acute psychiatric patients; (2) mental health services for children and adolescents; (3) services for the aged with psychiatric problems; (4) drug abuse and alcoholism; and (5) the general area of psychiatry and the law.

The committee supported a bill in the State Legislature to permit persons between the ages of 18 and 21 to receive psychiatric consultation and treatment without parental consent. A resolution was submitted to the Faculty regarding the transportation of emotionally disturbed patients from the community to psychiatric care facilities. The resolution was approved by the Executive Committee, but the Council declined to adopt the resolution as presented. The committee has again considered the resolution and reworded it to make it more clearly understood what is being recommended. This will be presented again to the Council for action.

Considerable thought and discussion have been given to the problem of the use of marihuana, including its possible legalization, and the present legal penalties which equate it with hard-core narcotics. The committee went on record as being in support of the prefiled bill for the State Legislature regarding penalties for use of marihuana. The policy statement of the AMA regarding marihuana was reviewed and a copy has been sent to the superintendents of schools in all the counties in Maryland. To date, several requests have been received for additional copies of the policy statement to be sent to the principals of all schools in certain counties.

The mental health services for children and adolescents are being looked into extensively. Some members of the committee have personally visited the state training schools. Plans are being made to hold the next committee meeting at one of the state mental hospitals in order to see what can be done to correct the undesirable situation present in many of these hospitals. The superintendent and staff physicians of the state hospital will be invited.

A resolution regarding psychiatric services for the aged is being submitted to the Executive Committee of the Faculty with the recommendation that it be made Faculty policy. A seminar on psychiatric units

in general hospitals is being planned at Prince George's General Hospital this spring. Also, a member of the committee will be one of the moderators at the Round Table Luncheon, held in conjunction with the Annual Meeting of the Faculty. The title of his discussion is "Psychiatric Admissions to General Hospitals."

The many bills regarding mental health, including narcotics, which are being introduced at the 1970 session of the State Legislature, are being studied and recommendations will be made.

Two members of the committee represented the Faculty at the Annual Conference of State Mental Health Representatives held by the AMA in Chicago in March. They went at their own expense as funds were not available from the AMA.

Respectfully submitted,

EXALL L. KIMBRO, JR., MD, *Chairman*
EDUARD ASCHER, MD
RICHARD H. EDENBAUM, MD
AUGUSTO J. ESQUIBEL, MD
THEODORE M. FELDBERG, MD
ERNEST E. HARMON, MD
STEPHEN A. HIRSCH, MD
JOSEPH P. NORRIS, MD
LOUIS W. TINNIN, MD
WITOLD V. WINIARZ, MD
ALAN B. ZIENTS, MD

FINANCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Finance Committee met with a counselor of the T. Rowe Price Company and reviewed the investment portfolio of the Faculty's special dedicated funds.

The market value of the portfolio was down 0.2% on December 31, 1969 compared to December 31, 1968. It is encouraging to note, however, that our portfolio compares favorably with the two popular market averages and the average of all mutual funds as indicated:

Standard & Poor 500	Off 11.4%
Dow Jones Industrial Average	Off 15.2%
Average of all Mutual Funds	Off 14.5%
Medical Faculty	Off 0.2%

At the year end, the total market value was $1,093,-283.29. The approximate income of the portfolio was $31,323.91. The yield on invested capital was 3.4%.

The request of the Postgraduate Committee that MEDIC be approved for a period of five years was discussed by the committee. The Treasurer pointed out that the limited funds of the educational fund would not cover the cost of MEDIC for five years. The committee agreed that approval of the program should be considered for only one year at a time.

The Treasurer advised the committee of the proposed Bylaw amendment of the Montgomery County Medical Society to establish an ad hoc committee to make recommendations to the Finance Committee with regard to the Faculty budget. The Treasurer will carry out the wishes of the House of Delegates, but opposes the proposal for several reasons. The function of the proposed committee is now being performed by the Executive Committee, made up of Council and House of Delegates electees who are most familiar with the Faculty operations and are more knowledgeable of the requirements and responsibilities of the Faculty than the proposed committee might be. Also, the requirement that facts and figures be made available six months in advance is not practical. The information obtained at such an early date would be of little value for preparation of the budget. The financial records through 11 months of the year are presently used in budget preparation. The Finance Committee agreed that the amendment should be opposed.

The committee was apprised of the deficit budget for 1970, and the efforts of the Executive Committee to eliminate or reduce the deficit. The Treasurer indicated that every effort will be exerted to operate within a balanced budget, but due to rapidly rising costs, the Faculty may have to consider increasing membership dues.

Respectfully submitted,

KARL F. MECH, MD, *Chairman*
M. MCKENDREE BOYER, MD
A. C. DICK, MD
E. W. DITTO, JR., MD
THEODORE G. OSIUS, JR., MD

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

The 1970 General Assembly session was one of the most active sessions during my tenure in office as legislative chairman. The lack of newspapers during most of the session necessitated daily visits to Annapolis by Faculty representatives to ensure that we were current with all legislation introduced.

Committees of the Legislature commenced working almost immediately following opening of the session. This is an almost unheard of phenomenon. Bills of interest to the profession were among the first heard in committee.

It is not necessary to brief you in this report on the various highlights of bills that were heard. Full details are contained in *The Assemblyman* which was mailed to all members during the session and immediately following adjournment. During the session it is almost a full-time task to keep abreast of legislative activity. Printing delays and work delays prevent issuing reports to the membership as often as we would like.

The committee cannot emphasize too much the importance of the assistance given the Faculty's representatives when component society members meet with their legislative delegation to discuss proposed or pending legislation. Such meetings do much to cement relationships and make our spokesmen in Annapolis known to individual delegates and senators.

This year, it was not necessary to form subcommittees to consider various legislative proposals. However, in line with the position of the Faculty to be on the offensive rather than on the defensive, it is planning to consider various legislative ideas during the summer months with a view to requesting sponsorship of legislation in the 1971 General Assembly. Details will be forthcoming at a later date.

In line with Faculty positions on various policy matters, testimony was presented at innumerable legislative hearings both during the General Assembly and during the summer months at Legislative Committee sessions.

Following procedure adopted last year, the Legislative Committee held its meetings over the MEDIC network thus obviating trips to Baltimore by many of the component society legislative representatives.

The First Aid Room was again in operation during the 1970 General Assembly Session and during the special legislative session held in late 1969. It was also activated during the all-day hearing conducted by the Governor in connection with the Abortion Repeal Bill (House Bill 489). We are again indebted to the Maryland Academy of General Practice for its provision

of physicians on call during the latter part of the session.

Respectfully submitted,

B. Martin Middleton, MD, *Chairman*
Marshall Diamond, MD
John Fenwick, MD
Stephen K. Padussis, MD
J. Morris Reese, MD
Roland T. Smoot, MD
C. C. Spencer, MD
William A. Williams, MD
Elmer Linhardt, MD
John Cappuccio, DDS
Mrs. DeWitt E. DeLawter

LIAISON COMMITTEE

Mr. President and Members of the House of Delegates:

Only two meetings of the main Liaison Committee were held during the past year. However, the various subcommittees met on a regular basis as subjects for discussion necessitated such meetings. The Nursing Liaison Subcommittee met on four occasions, as did the Nursing Home Liaison Subcommittee. The Pharmacy Liaison Subcommittee met once.

The former subcommittee on Medicine and Religion became a full standing committee at the Annual Meeting in 1969 and, therefore, the responsibilities of the Liaison Committee in this connection ceased.

In addition to the activities of the subcommittees reported below, the Liaison Committee determined that it would be desirable to establish some type of liaison with hospital emergency room personnel and other groups involved in emergency care. As a consequence, it decided to invite representatives from the State Police, Hospital Council, Emergency Room Physicians, and others, to attend a future meeting of the committee.

William L. Stewart, MD, was designated to work with the State Health Department and the State Scholarship Bureau on details of areas of need where physicians could fulfill their scholarship obligations in the State of Maryland. This has been accomplished and the guidelines have been revised.

Nursing Liaison Subcommittee

This subcommittee considered a proposed protocol for Mobile Coronary Care Units at the request of the Montgomery County Medical Society. This necessitated modification of the Faculty's position with respect to nurse responsibilities in Coronary Care Units of hospitals.

Also considered is the practicality and ethicality of individuals other than licensed health professionals interpreting tuberculin tests obtained through a mass survey by the Baltimore City Health Department. It was determined that "technicians" (who are unlicensed) should not become involved in anything that required medical judgment. Mechanical procedures, however, could be performed by such individuals after qualifying training, the subcommittee determined.

A representative of the subcommittee attended the second National Nursing Conference held in Chicago on April 11-12, 1969 and reported to the subcommittee that Maryland is far ahead of most other states in defining the responsibilities of registered nurses and other nursing personnel.

The subcommittee has also given consideration to the use of paramedical personnel, both in and outside of institutional settings. Three guidelines must be used in determining the degree of professional care required in given cases: mechanical procedure, use of judgment and the training of the individual. This will be a subject for discussion at future meetings.

At another meeting, the entire Nurse Protocol was examined and revised where necessary. This was submitted to the Executive Committee which approved the revisions. The proceeding was published in the *Maryland State Medical Journal.*

Discussion is still taking place with respect to protocol for nurse-midwives. It had been planned, by interested parties, that legislation would be introduced defining what activity such persons could engage in. However, attempts are being made to treat nurse-midwives as all other registered nurses and define their practices in the protocol as agreed to by all groups involved.

Nursing Home Liaison Subcommittee

This subcommittee discussed proposed legislation for licensure of nursing home administrators as required under federal law July 1, 1970. It also discussed its responsibilities and whether or not it should establish guidelines for medical practice in nursing homes.

Discussion also took place with regard to the reasonableness of the nonreimbursable items in nursing homes under Medicaid; as well as guidelines for Classifications of Nursing Home Facilities.

Pharmacy Liaison Subcommittee

During the year it was learned that despite ethical rulings by both the Maryland Pharmacy Association and the Faculty, the C&P Telephone Company has determined it can take no action to deny "direct lines" between a physician's office and a pharmacy.

At the one subcommittee meeting, discussion centered around activities of physicians and their use of prescriptions. Some apparently indicate "DO NOT REFILL WITHOUT PERMISSION" or "DO NOT DISCUSS WITH PATIENT". The chairman indicated that he would speak to the physician involved and ascertain the necessity for doing this as policy on this is already established in the Pharmacist/Physician Code of Cooperation.

Other matters discussed included the proposed legislation that would prohibit dispensing of cough syrups containing narcotics (in Baltimore city) without a physician's Rx; as well as the Generic Prescribing Bill that was enacted in 1969.

Respectfully submitted,

John Kehoe, MD, *Chairman*
Manning W. Alden, MD
Melvin Borden, MD
Robert E. Farber, MD
Paul F. Guerin, MD
John H. Hirschfeld, MD
Donald W. Mintzer, MD
William J. Peeples, MD
E. L. Pessagno, DDS
John F. Schaefer, MD
William L. Stewart, MD
H. Leonard Warres, MD

LIBRARY AND HISTORY COMMITTEE
FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

The Library and History Committee held very few meetings during 1969, but progress was accomplished toward modernization of furnishings, more efficient use of space, weeding of the collection, and revising the catalog and classification systems. All these activities contribute to a more comfortable working arrangement

of the library reading room area, as well as updating our library system throughout.

The long table was replaced by one reference table for current indices which are constantly in use, plus three carrels for individual study, and a 72-drawer catalog cabinet to match the one purchased earlier. This frees space occupied by the table alone. Despite this and the removal of all History of Medicine volumes to the stack area, near the rare books, the Reading Room is not adequate for the collection now housed there, dating from 1950 publications. The Periodical Room is more crowded than ever and there seems to be no solution to this problem. Space for expansion of bound journals is nonexistent. We continue to discard duplicates and segregate volumes of books and journals for auction later.

In September two part-time staff members resigned, Mrs. Jane Parsons and Miss Beatrice Marriott, and were not replaced. This caused a lag in ordering new materials and processing same, and reduced the number of literature searches the staff was able to make. Also, Mrs. Margaret Gross, clerical assistant, was forced to resign because of illness. She was replaced by Mrs. Susan Saylor for one and a half months until her husband was transferred and she, too, had to move. With these handicaps it was a rather rugged year for the library.

The librarian participated in several local and regional programs, serving as Medical Society Group Chairman at the Medical Library Association annual meeting in Louisville, Kentucky in October where Mr. Lee Ash spoke about the various medical library surveys he has conducted around the country, including, of course, our own. W. I. Hume, Jr., MD, president of the Jefferson County Medical Society in Kentucky, also spoke. Mrs. Sanford also attended the International Congress for Medical Librarianship in Amsterdam, May 5-9, 1969.

The Library furnished the usual collections of books for the Med-Chi Annual and Semiannual meetings, as well as an exhibit for the Sports Seminar in the fall for which we updated the bibliography of Sports Medicine, started several years before. Another bibliography, *Emergency Room Management,* was requested for listing by The National Institutes of Health.

The "Ash Project" to establish the History and Rare Book Division of the Library is nearing completion. This has been a major effort in selecting material to be housed in the division. Several thousands of books have been chosen by our consultant and we are beginning to catalog them correctly and put them into a semblance of order so that they can at last be useful to researchers.

Next steps are to inventory the *old* "C" (rare book) collection, compare duplicate copies throughout the division, and then select such duplicates and out-of-scope books as can be sold at public auction for the benefit of the library. This is to be done as soon as possible.

The consultant has begun to examine the thousands of rare pamphlets (many are "classics" of medicine) that are either loose or bound together in "pamphlet volumes". Many of these are of unusual value and will probably prove to be saleable duplicates or out-of-scope items. Also, the Osler Collection (books and pamphlets, and letters by or about him) is being put in order at last, a project that will be completed this summer by student help working under Mr. Ash's direction. This summer we hope to begin a project to bring Med-Chi's large collection of unique manuscript materials and prints under a control and conservation program.

Since no History and Rare Book Division librarian has been hired, Med-Chi is fortunate to be able to continue to have the attentive supervision of its consultant in order to help establish and arrange its collection into what will become one of the nation's leading research resources.

LIBRARY STATISTICS—1969

Circulation	
Books	3,360
Journals	6,362
Pamphlets (V.F.)	350
Total	10,072
Interlibrary Loans	
Interlibrary loans requested by Med-Chi (outgoing)	369
Interlibrary loans requested by other libraries (incoming) (This includes local requests charged out at circulation desk)	4,518
Attendance	2,251
Courtesy cards issued	10
Gifts	
Books	887
Journals	995
Total	1,862
Pages Xeroxed	10,608
Bibliographies	211
Acquisitions	
Bound journals	415
Books added	992
Total	1,407
Volumes withdrawn (Books)	366
Previous total volumes in collection	93,077
Total volumes in collection	94,118

Respectfully submitted,

Library and History Committee

PAUL F. GUERIN, MD, *Chairman*
ROBERT B. GOLDSTEIN, MD
THOMAS C. HILL, MD
KATHARINE A. CHAPMAN, MD
GEORGE A. MAXWELL, MD
H. BALDWIN STREETT, DDS

Finney Fund Committee

D. C. W. FINNEY, MD, *Chairman*
RICHARD W. TELINDE, MD
RICHARD V. HAUVER, MD
JOHN P. HABERLIN, MD
RICHARD G. COBLENTZ, MD

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Mr. President and Members of the House of Delegates:

As Chairman of the Maryland Medical Political Action Committee I would like to first of all express my thanks to the Medical and Chirurgical Faculty for its great cooperation since this organization really got under way in 1962.

We owe particular thanks to Mr. Sargeant and his staff who have helped us so much with the administration and billing and all the details of interviewing candidates. We are indebted to Dr. Mech and the Executive Committee for approval of the joint billing in which your bill for dues of Maryland Medical Political Action Committee and AMPAC, our parent organization, are included on the same billhead as Med-Chi dues. This has obviously been a great boon to our membership. As is inevitable, a few physicians

have paid their dues without realizing the inclusion. After talking with them, most agree this is a good thing to do. I'd like to convince the leaders of medicine in this community—namely yourselves—to become interested in MMPAC and with this in mind, I would like to take a second to give you some background.

The American Medical Political Action Committee is here to stay. It is the fourth largest political action movement in the country, being next to the National Democratic and Republican Parties and COPE, labor's political arm.

Our own state organization started with a few members in 1962. We are now ranked about 20th in size in the country. We provided the margin of victory for Larry Hogan in the 5th District two years ago when we evened up our state delegation to Congress—four Democrats and four Republicans. We provided significant support to Gilbert Gude and J. Glenn Beall, and we have provided support for other candidates. We have tried desperately to maintain our bipartisan posture. We interview all candidates. We judge the candidates only on their ability to serve in a fair and honest fashion, and we are interested, obviously, in their willingness to communicate with us on medical issues.

I think Dr. Fisher brought it into focus that if we don't elect people to Congress who are willing to engage in free and open communication with the medical community, we will be in serious trouble, and there's no doubt that coordinated, meaningful candidate support and money coming from a central group is much more effective than each individual supporting his own candidate. Certainly we want everyone to get behind his own individual candidate, but it is more meaningful to have group and financial support, and I can tell you that all the candidates who ran two years ago, as well as those who are getting ready to run this time, are very aware of this fact.

Our other goal, of course, is political education and in this regard we send out a regular newsletter so that we, as physicians, can be informed about the candidates and the issues coming up. We are indebted to Mrs. Karl Mech who has done such a wonderful job with our newsletter over the past years.

At our national workshop, which was held in Washington three weeks ago, almost everyone who is knowledgeable in predicting the political future was convinced that some sort of National Health Insurance Program will come before Congress in the next two years in some form or other. This should be enough of an impetus to get us into the game.

We have district chairmen in every congressional district. We can provide you with their names. If you want to contribute or ask your wife to contribute time to candidate support, we have the organization to do this and you can do it through your own Board of Directors and men working in your own Congressional district. We ask you to please do so.

I must repeat one remark Mr. Scammon, who is an astute political observer, made in his closing statements in Washington recently. He said: "I don't like to agree with Mr. Buckley, but I thought his definition of Democracy was the best I ever heard. This was that he would rather be ruled by the first two thousand names in the Boston phone book than the entire Harvard Faculty." I think we better start going through our phone book and find support and elect candidates who can effectively represent us in the halls of Congress. If we don't, you can be sure no one will do it for us.

Respectfully submitted,

GEORGE G. FINNEY, JR., MD, *Chairman*

MARYLAND MEDICAL SERVICE, INC. BOARD OF DIRECTORS

Mr. President and Members of the House of Delegates:

Maryland Blue Shield continued its established pattern of growth and progress in 1969. Enrollment continued to increase; the number of claims processed rose sharply; subscription income was substantially greater than in 1968, with a corresponding increase in benefits paid; phasing down of Plan A enrollment, and acceleration of enrollment in Plan C continued; the number of participating physicians again increased; and further administrative improvements were effected.

Plan membership at year's end was 1,159,177, an increase of 62,132 (5.6%) over 1968. Though the National Association of Blue Shield Plans has not yet published year-end figures, their report for the first nine months records an average percent of growth of 3.36% for all 73 U. S. Plans. The Maryland Plan did substantially better than the average, having increased its enrollment by 4.85% in the first nine months. At the end of the year, Blue Shield membership had reached 88% of that of our companion Blue Cross Plan, compared with 86% the previous year.

The overall growth in enrollment was characterized, as planned, by a substantial gain in Plan C and continuing growth in Plan B, while Plan A showed a significant decline. At the end of 1969, Plan A accounted for only 8.8% of total enrollments, compared with 10.8% a year earlier. Plan C enrollment was increased by 90,000 to a total of 330,000 during the year; at year's end it accounted for 28% of total Blue Shield membership.

The number, as well as the total monetary amount of claims paid during the year, showed a sharp increase. Payment was made for 973,050 separate services, an increase of more than 60% over the 606,359 paid in the previous year. The total dollar amount paid in 1969 was $24.7 million, and in 1968, $18.7 million. The increase in Plan enrollment, particularly under Plans B and C referred to above, accounts for some of this difference; a larger part, however, results from the popularity of the diagnostic endorsements, which heavily increase both the number and the total value of claims.

Maryland Blue Shield's activity as the intermediary in Maryland for federal government programs showed an increase also. The number of Part B Medicare claims processed increased by 9.9%, from about 358,000 in 1968 to nearly 394,000 in 1969. The amount paid increased by 13%, from less than $11 million in 1968 to $12.3 million in 1969. Most Faculty members will recall that Part B Medicare payments were limited by the Social Security Administration to the levels being paid as of December 31, 1968. This limitation continued throughout the year and, in addition, more specific instructions were issued by SSA as to the statistical methods to be employed in determining usual charges and prevailing fee ranges.

Maryland Blue Shield, in 1969, increased its activities in utilization review, formally established a separate department devoted exclusively to that activity. This activity, involving review of individual physician's claims records, is designed to ensure the most economical and effective use of covered services under both Medicare B and our own underwritten programs, for the mutual benefit of physicians and the entire community.

The number of Maryland physicians who have agreed to participate in Maryland Blue Shield increased from 3,765 as of December 31, 1968, to 3,858 as of December 31, 1969, or more than 90% of the physicians in private practice in the state. Professional Relations representatives of Maryland Blue Shield made 3,916 visits to physician's offices, and participated in 13 meetings of physicians or physicians' staff or clerical personnel.

Finally, consistent with the revised operating agreement negotiated with Maryland Blue Cross in 1968, as of January 1, 1969, all employees engaged solely in Blue Shield work became employees of Blue Shield. And, to better identify the Plan in the community, its corporate name was officially changed to Maryland Blue Shield, Inc., on January 1, 1970.

Respectfully submitted,
J. Sheldon Eastland, MD, *Chairman*

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

On January 26, 1970, the Editorial Board met to discuss various aspects of Journal operation including local advertising in view of cost versus income, publishing on a ten- or eleven-month basis rather than twelve months, special issues, supply of manuscripts and transcripts, printers' bids, Journal format in regard to cost and effectiveness, scheduling regular meetings of the Board, and the Membership Directory in regard to cost versus value, annual or biennual publication, format, and information it should contain.

Since the Journal is in financial difficulty, it was previously decided by the Executive Secretary, the Comptroller, and the Managing Editor to contact another advertising agency which would be willing to take less than 45% of the local advertising income—the rate of commission at which we are now under contract to provide to the present agency—and which would be more responsible in contacting prospective advertisers with regard to Journal policy established by the Council, and with regard to a generally more attractive appearance of the local advertising. Mr. Paul Moore of the Ruehl and Co., Inc., advertising and public relations firm, was contacted and has agreed to accept the job of selling and preparing the advertising on a 25% commission.

Mr. Moore appeared before the Board and presented his proposal which was favorably accepted. Dr. Flotte made a motion to recommend a change in advertising agency to the Executive Committee at its meeting on February 12. Dr. Lisansky seconded the motion.

The Executive Committee accepted the recommendation and agreed to bring it before Council on March 19, 1970. Council subsequently approved the measure and Mrs. Sally Ladin Ogden, our present advertising agent, has been informed of the termination of the contract as of the last day of September 1970 according to the terms of the agreement drawn up in 1962.

The suggestion of reducing the number of Journal issues was also taken before the Executive Committee and was rejected as not practical.

The Editorial Board agreed that the Journal should continue its special issues and the grouping of independent manuscripts to form such issues when feasible. It was also decided that transcripts would no longer be requested or accepted since the supply of prepared manuscripts is more than sufficient.

The Journal is to be put out to bid every 18 months and in February three printing establishments were contacted, only one of which is now preparing an estimate. The other two were not equipped to handle a book of this size. A fourth printing firm has just been contacted.

The Editorial Board did not favor a change in Journal format in order to cut costs and agreed that improved readership depends upon an attractive graphic presentation as well as content.

The Board agreed to hold three meetings a year from now on.

On Friday, April 3, 1970 the Board met to discuss the Membership Directory. The members agreed that the Directory is rarely used by them and it was decided that it will be published every other year and will be incorporated as an issue of the Journal rather than in its present book form. From time to time the Journal staff will prepare an errata, a list of changes and names of new members which will be published. Dr. Flotte is investigating the possibility of using the AMA's magnetic tape to facilitate production. Also under discussion is the possibility of incorporating the Board of Medical Examiner's list of newly licensed physicians in Maryland.

In September, the Editor and Managing Editor attended the State Medical Journal Advertising Bureau's biennual conference in Chicago. The Managing Editor is also scheduled to attend the American Society of Association Executives Publications Conference in Chicago in April 1970.

A new staff member, Mrs. Debby Anderson, joined the Journal as Assistant Editor in September 1969.

At the end of December, the term of Moses Paulson, MD, was completed and J. B. Zachary, MD, was appointed to his position on the Editorial Board.

The Journal is still receiving favorable comments and our circulation is increasing. And, according to the results of the Faculty survey, testing its facilities and services, the Journal is read second only to specialty journals by the membership.

Respectfully submitted,
C. Thomas Flotte, MD, *Editor*
Judy Sowell, *Managing Editor*
Debby Anderson, *Assistant Editor*

Editorial Board
Leon W. Berube, MD
Wilber R. Ellis, Jr., MD
Edward S. Klohr, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
J. B. Zachary, MD

MED-CHI INSURANCE TRUST

Mr. President and Members of the House of Delegates:

The Med-Chi Insurance Trustees are continually striving to improve the various programs that are available to members of the Faculty through the Trust administration. The programs administered by the Trust are: (1) Accident and Sickness Disability Insurance (2) Major Medical Expense Insurance (3) Blue Cross and Blue Shield (4) Business Expense Disability Insurance (5) Life Insurance, and (6) Keogh Retirement Plan.

The *Accident and Sickness and Major Medical* programs, underwritten by the Hartford A and I Company, were liberalized effective November 1, 1969. The four main changes were to: increase Major Medical maximum benefit from $15,000 to $20,000; increase daily private room limit to $60 per day; increase coinsurance percentage from 80% to 90%; and free inclusion of

$10,000. Accidental Death and Dismemberment benefits on insured members plus $5,000 on spouse if no children, or $4,000 on spouse and $1,000 on each child. Rate reductions became effective November 1, 1969: under age 40—25% reduction, 40 to 49—15%, 50 to 59—10%, 60 and over—5%.

The *Major Medical and a five year accident—two year sickness disability* program will be available to employees of insured members in 1970.

The *Blue Cross and Blue Shield* group has been under study. Hopefully in 1970, insured members will be able to include their assistants in the Faculty group. Also, for a very nominal rate increase, the program can be changed to a 70-day plan with diagnostic coverage.

The *Business Expense Disability* program, underwritten by the St. Paul Insurance Company, has increased the limits of coverage from $1,000 a month to a maximum of $1,500 a month. This change will be announced in 1970.

The *Life Insurance* program, underwritten by the Minnesota Mutual Life Insurance Company, has grown in participation. Last year the subscribers were sent a 9% cash dividend. This year each participant will have the option of taking a cash dividend or having a higher dividend applied against the insurance premium. This program is also under study for possible improvements.

The *Med-Chi Members Retirement Plan* had a most successful year. As of December 31, 1969, there were 486 participants in the plan. The equity fund approximated $1,000,000. The fund enjoyed a 6.3% gain in value for the year, which is the best performance of all physician funds throughout the country. Significantly, the Dow Jones Industrial Average was down 11.6% for that same period.

We are happy to report this successful year of operation. It is our hope the programs will continue to receive the enthusiastic support of the membership.

Respectfully submitted,

PAUL F. GUERIN, MD, *Chairman*
HARRY J. CONNOLLY, MD
WILLIAM J. MCCLAFFERTY, MD
RICHARD F. MOSCHELL, MD
ALFRED S. NORTON, MD
RICHARD A. YOUNG, MD

MEDIATION COMMITTEE

Mr. President and Members of the House of Delegates:

The Mediation Committee has held meetings at least once a month during the past year. In fact, the average, including various subcommittee meetings, would exceed this ratio. There seems to be an increasing number of knotty problems being presented to the committee for solution, with more and more appeals being heard from decisions made on a local level.

The committee has developed guidelines for use by component societies in the handling of grievances and, hopefully, these are of some assistance in handling the cases expeditiously and thoughtfully, and in resolving the problems.

A total summary of cases handled locally and on the state level is attached to this report.

During the past year, activities of the committee have resulted in the voluntary surrender of licenses to practice medicine and surgery by three physicians; and the committee has recommended stronger measures to the Commission on Medical Discipline for four other cases presently pending before the commission.

All physicians involved in the so-called Medicaid scandal of Baltimore city have been interviewed with the exception of two physicians who have elected to take their cases to trial in court. No decision has been rendered by the committee with respect to these cases, pending the outcome of the trial of the pharmacist involved and the two physicians whose cases were still pending trial at the time of the 1970 Annual Session.

During the year, cases other than disputes between patients and physicians that were heard and settled by the committee included:

1. Clarification of the practice of a hospital charging a percentage of the sums collected for physician's services rendered in that institution. Such a practice is unethical.
2. Referred to the Board of Medical Examiners instances that have come to light in which unauthorized persons have been practicing medicine.
3. Clarification of rental of office space to a group of physicians on a percentage basis, which is unethical.
4. Denied in some instances and granted in others, exceptions to the Faculty's policy with respect to Yellow Pages telephone listings.
5. Recommended various policy matters to Council for approval.
6. Conducted a study of the number of abortions performed during the six months of the revised law dealing with therapeutic abortions (July through December 1968).
7. Misuse of a physician's Blue Cross symbol.
8. Developed a policy with respect to hospital solicitation of patients for research projects.
9. Determined that a physician should itemize his bill to assist his patient in collecting Medicare benefits.
10. Reviewed Faculty policy with respect to hospital privileges for podiatrists and recommended a change in this to the House of Delegates.
11. Determined that distribution of a list of "Guild Opticians" by ophthalmologists was not in violation of ethics.
12. Adopted a policy of nondiscrimination with respect to acceptance of patients by physicians.

The committee is gravely concerned over the practice of some institutions which openly solicit patients, a practice which physicians are prohibited by law from doing. The committee currently has under consideration disciplinary action against physicians who are directly or indirectly associated with institutions that so solicit. It is self-evident that a physician must be guided by ethical and legal regulations, and that benefiting from solicitation conducted by an organization is as much a violation as if he made such solicitation himself.

In response to newspaper reports that Maryland was becoming an "abortion mill", a subcommittee composed of Drs. Reese, Linhardt, Sullivan, Cushner, and Mr. King was named to obtain statistical information on the first six months of operation under the abortion statute that took effect on July 1, 1968.

The results indicated that the newspaper statements were inaccurate and that less than 10% of the therapeutic abortions performed in Maryland were on out-of-state residents.

The Subcommittee on Narcotic Prescribing Practices of Physicians continued in existence and met with physicians whose prescribing practices of controlled drugs was brought to their attention. This has resulted in cutting short what might turn into illegal or unethical practices by physicians.

This subcommittee also has met and continued to monitor the Methadone Blockage programs in the state. It will continue to act as liaison for the committee in this area. Its members are Drs. Louis J. Kolodner,

Chairman, and J. Morris Reese, John B. De Hoff, Henry C. Mellette and Stephen A. Hirsch.

Until the formation of the Peer Review Committee, a subcommittee on Utilization Review has been active in reviewing questionable practices by physicians in the Medicare and Medicaid programs. In all cases brought to the attention of the subcommittee for consideration, a satisfactory resolution of the problem was reached. Subcommittee members included Drs. Robert B. Goldstein, Katherine H. Borkovich, and Worth B. Daniels, Jr.

On the advice of legal counsel, the committee is now proceeding to hear cases in which physicians are charged, under the law, with violations of various statutes. Previously, it has been the practice to wait until the courts had disposed of these matters. Sometimes it took years. It is hoped that speedy disposition of such matters will effectively show the public and the courts that the profession is anxious and willing to discipline wrongdoers within the profession.

During the past year, there have been several instances in which physicians have been openly dispensing or prescribing controlled drugs without there being any medical indication for them. As information is brought to the committee, the individual physician is called in for an interview. To date, there has been no problem in persuading the physician to cease such practices.

Respectfully submitted,

LEWIS P. GUNDRY, MD, *Chairman*
KATHERINE H. BORKOVICH, MD
ROBERT B. GOLDSTEIN, MD
LOUIS J. KOLODNER, MD
HENRY C. MELLETTE, MD
CHARLES F. O'DONNELL, MD
HILARY T. O'HERLIHY, MD
ROLAND T. SMOOT, MD
WILLIAM J. SULLIVAN, MD
HENRY C. WELCOME, MD
ROBERT vL. CAMPBELL, MD
J. MORRIS REESE, MD
ARTHUR G. SIWINSKI, MD
RICHARD D. BAUER, MD
RUSSELL S. FISHER, MD

Component	Total	Complainant	Defendant	Mutually	Pending 12/31/69	No Action	Referred to Med-Chi	Remarks
Allegany County	1				1			
Anne Arundel County	9	2	2	5				
Baltimore city	77	8	42	10	13	2	2	
Baltimore County	21	3	12		2		4	
Calvert County	2	2			0			
Caroline County								
Carroll County	0							No complaints
Cecil County	2	1	1		0			
Charles County	0							No complaints
Dorchester County	0							No complaints
Frederick County	0							No complaints
Garrett County	0							No complaints
Harford County	0							No complaints
Howard County	0							No complaints
Kent County	2		2		0			
Montgomery County	56	11	25	13	7			
Prince George's County	22	2	19		1			
Queen Anne's County	0							No complaints
St. Mary's County	0							No complaints
Somerset County								
Talbot County	0							No complaints
Washington County	7	4	3		0			
Wicomico County	4		4		0			
Worcester County	0							No complaints
TOTAL	203	33	110	28	24	2	6	

The Faculty considered a total of 66 cases of unethical activity on the part of physicians. Of this total, 44 cases were resolved; 12 cases were referred to the Board of Medical Examiners; and 10 cases were still pending as of December 31, 1969.

MEDICAL ECONOMICS COMMITTEE

Mr. President and Members of the House of Delegates:

Five meetings of this committee were held during the year. The majority of the time was spent in adjudicating what are usual or customary fees for which insurance carriers are liable under their major medical policies. Nearly all problems were solved satisfactorily.

Educational endeavors, with respect to pitfalls for malpractice insurance cases, were continued. During the year, your chairman and Faculty legal counsel spoke at ten meetings of hospital staffs throughout the state. This is a worthwhile endeavor and one that will be continued as time and availability of speakers warrants.

One instance in which a carrier refused to pay out-of-hospital benefits under his policy when he would have paid for the same service if it were performed in a hospital was discussed. It was the consensus of the committee that this is bad practice and only points up the problems associated with the hard and fast rule that some insurance carriers follow in interpretation of the policy benefits. The committee is of the opinion that this can only increase total costs to the carriers, the public and government. Despite a meeting with representatives of the local Health Insurance Council, no headway was made in this regard.

The committee also discussed questions that are being raised about Blue Shield by some nonparticipating physicians. Under Blue Shield's usual, customary, and reasonable payment schedule for Plan C, a determination is being made by BS as to what the physician's charge shall be. The committee also finds this reprehensible and is currently discussing this matter with Blue Shield so as to prevent misunderstandings both by the patient and the physician.

As are all physicians, the committee is concerned over the continued increase in professional liability insurance premiums. Discussion is taking place looking toward some alternatives. When and if a proposal is available, it will be presented to the appropriate governing body of the Faculty for its consideration.

Respectfully submitted,

W. Kenneth Mansfield, MD, *Chairman*
Fred N. Cole, Jr., MD
Thomas Crawford, MD
Alfred S. Norton, MD
Samuel H. Bryant, DDS

MEDICAL TISSUE DONATION COMMITTEE

Mr. President and Members of the House of Delegates:

Recognizing the possibility of uniformity in donor cards and also the practicality of coordinating efforts in this area, the Faculty sponsored this committee. Representatives, as indicated at the conclusion of this report, attended the seven meetings of this group.

Those responsible agreed to a telephone listing under which a person at a central telephone would obtain names and addresses of individuals who were interested in donating any or all of their organs or entire bodies after death. A central registry was considered desirable and one was established on a trial basis.

In cooperation with the Attorney General's office, a form was developed and limited supplies were printed. It has since been ascertained that the form is confusing to those filling in the essential information and that it should be revised.

There is a serious question as to the advisability of continuing the central operation and telephone listing. This will be considered at a future meeting of those involved and a conclusion will be reached.

This group is cited as one example where the Faculty acts as a leader and a catalyst to get the interested groups working together toward a common goal.

Respectfully submitted,

Russell S. Fisher, MD, *Chairman*
Cornelius J. Burns, MD
Edward J. Hinman, MD
Richard Richards, MD
Marvin Cornblath, MD
William Esmond, MD
Robert Levy, MD
Richard Barth
Frederick N. Griffith
William Snyder

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

At the Semiannual Session in September 1969 the term of office for this committee was changed to coincide with the presidential year of the Maryland State Bar Association. This report, however, covers only the Faculty presidential year, even though the term of office of committee members will be through July 1970.

As is the custom, various subcommittees took under consideration specific areas of concern as defined by their titles. The subcommittee activity was as follows:

Subcommittee on Interprofessional Relations

This subcommittee met on three occasions to discuss complaints made by physicians against attorneys, and by attorneys against physicians. Most of these have been settled on a relatively amicable basis. As recommended by the subcommittee and by the Medicolegal Committee, an amendment to the Medicolegal Code of Cooperation has now been approved by both the Bar Associations and the Faculty. This new provision should make it clear as to who is responsible for payment of fees for reports and other information supplied to attorneys, as distinct from charges for medical services to the patient.

This constituted the bulk of the complaints handled in this subcommittee.

Symposia Subcommittee

This subcommittee arranged for a panel to discuss "Psychiatric Relationship to Trauma" for the annual mid-winter meeting of the State Bar Association.

No similar program was arranged for physicians.

The Medicolegal Committee declined to approve a medical release and assignment form that was developed in the Subcommittee on Interprofessional Relations.

Respectfully submitted,

Robert W. Johnson, III, MD, *Chairman*
Conrad Acton, MD
William D. Boyd, MD
Rudiger Breitenecker, MD
James D. Drinkard, MD
Clinton R. Harrison, MD
Paul Huffington, Jr., MD
Howard F. Kinnamon, MD
J. Elliot Levi, MD
Jonas Rappeport, MD
Belden R. Reap, MD
John F. Strahan, MD

Lawyer Members

JOHN F. KING, ESQ., *Chairman*
JULIUS BRONSTEIN
CALVEN E. COHEN
JAMES J. CROMWELL
ROBERT A. DIEMER
DELVERNE A. DRESSEL
HAMILTON P. FOX, JR.
BERNARD M. GOLDSTEIN
OMER T. KAYLOR, JR.
BERNARD J. MEDAIRY, JR.
JOSEPH I. PINES
EDWARD W. SMITH

NOMINATING COMMITTEE

Mr. President and Members of the House of Delegates:

The following names are being presented for your consideration for election to office. Those elected will assume office at conclusion of the Annual Meeting 1971, unless otherwise indicated.

President-elect

John F. Schaefer, MD, Baltimore — President-elect 1970-71; President 1971-72

First Vice President
Raymond M. Yow, MD, Salisbury (1972)

Second Vice President
John H. Hornbaker, MD, Hagerstown (1972)

Third Vice President
Louis J. Kolodner, MD, Baltimore (1972)

Secretary
William A. Pillsbury, MD, Timonium (1972)

Treasurer
Karl F. Mech, MD, Baltimore (1972)

Councilors

Central District
John T. Chissell, MD, Baltimore (1974)
John M. Dennis, MD, Baltimore (1974)
J. Morris Reese, MD, Lutherville (1974)
James B. Brooks, MD, Baltimore (1974)
Philip H. Heuman, MD, Bel Air (1974)

South Central District
John G. Ball, MD, Bethesda (1974)
Wolcott L. Etienne, MD, College Park (1974)
Seruch T. Kimble, MD, Silver Spring (1974)

Eastern District
Francis J. Townsend, MD, Ocean City (1974)

Southern District
J. Parran Jarboe, MD, La Plata (1974)

Delegate to the American Medical Association
Charles F. O'Donnell, MD, Towson (Jan. 1, 1971-Dec. 31, 1973)

Alternate Delegate to the American Medical Association
Arthur E. Cocco, MD, Baltimore (Jan. 1, 1971-Dec. 31, 1973)

Committee on Program and Arrangements
Albert M. Antlitz, MD, Baltimore (1970-74)
J. Donald Drinkard, MD, Towson (1971-75)

Library and History Committee
Harold H. Gist, MD, Hagerstown (1970-71)
Thomas C. Hill, MD, Salisbury (1971-76)

Finney Fund Committee
William H. M. Finney, MD, Baltimore (1976)

Board of Medical Examiners
William L. Stewart, MD, Westminster (June 1970-June 1974)
Elmer G. Linhardt, MD, Annapolis (June 1970-June 1974)

Respectfully submitted,
ARTHUR G. SIWINSKI, MD, Baltimore, *Chairman*
ELMER G. LINHARDT, MD, Annapolis, *Southern District*
PHILIP W. HEUMAN, MD, Bel Air, *Central District*
ROBERT W. FARR, MD, Chestertown, *Eastern District*
CHARLES C. SPENCER, MD, Hagerstown, *Western District*
WILLIAM A. HOLBROOK, JR., MD, College Park, *South Central District*
CLAUDE D. HILL, MD, Baltimore, *Member-at-Large*

OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE

Mr. President and Members of the House of Delegates:

Two meetings were held by this committee—the scope and responsibilities of which were broadened by action of the House of Delegates at the Semiannual Session. Two new members were added to the committee, one a representative of the Faculty's Traffic Safety Subcommittee, for the purpose of coordinating efforts of committees with similar charges. It is believed that further expansion of the committee may be desirable.

The assistance of this committee was offered to the Secretary of Health and Mental Hygiene in matters concerning environmental health of the community.

The Governor's Award to a Physician for Promotion of Employment of the Handicapped was awarded to Isadore B. Lyon, MD, of Washington County, whose nomination was made directly to the Governor's Committee. Since this committee had nominated Lomax Wells, MD, a special award was made to him by the Governor's Committee in view of the fact that he serves on the President's Committee and would be ineligible for the original award. A letter was addressed to the Governor's Committee indicating that future nominations would be made through the Faculty, rather than through the component societies.

Mr. Howard Chaney, Director of the Bureau of Consumer Protection, Department of Health and Mental Hygiene, was a guest at one meeting and explained the functions of his department.

Note was made of the air pollution programs being conducted by George Washington University Medical Center and prepared for television presentation. If the programs are aired in Baltimore, names of physicians to participate will be given to the television studio if requested.

State and federal legislation was discussed briefly.

Respectfully submitted,
HAROLD P. BIEHL, MD, *Chairman*
JOHN R. DAVIS, MD
WALTER E. FLEISCHER, MD
DONALD J. ROOP, MD
EDWARD WITOWSKI, MD
FRANCISCO G. JAPZON, MD

POLICY AND PLANNING COMMITTEE

Mr. President and Members of the House of Delegates:

Several items were discussed during the past presidential year. The question of utilization review, rereferred to the committee by the House of Delegates at the 1969 Annual Session, was reconsidered and a proposed Bylaw amendment was submitted for approval of the House at the 1970 Annual Session. This amendment was drafted by the Bylaws Committee, on recommendation of the Faculty's Council.

A survey of Faculty membership to ascertain what is known about Faculty services and benefits was recommended and approved. This has been conducted and the responses are currently being tabulated.

Other items discussed within the committee, but with no positive action being taken at this time, included a study of the health manpower (physician) shortage in Maryland; a study to combine all medical society controlled scholarship and loan programs; a study regarding a proposed Division of Research and Planning within the Faculty; a study on a data processing system for Faculty membership records; and the financial responsibility for benefits accruing to all physicians in Maryland whether or not such persons are Faculty members.

At the time of this writing, an in-depth consideration of the AMA Committee on Long Range Planning report is scheduled for early in the next presidential year. This study will be reported to the Council for its consideration and action.

Respectfully submitted,

ARTHUR T. KEEFE, MD, *Chairman*
MANNING W. ALDEN, MD
CHARLES BAGLEY, III, MD
J. TYLER BAKER, MD
WILBUR N. BAUMANN, MD
RICHARD T. BINFORD, MD
KATHERINE H. BORKOVICH, MD
HENRY A. BRIELE, MD
ROBERT J. DAWSON, MD
ROBERT D. DIETZ, MD
OSMAN Z. ERSOY, MD
RICHARD L. FRUTH, MD
GEORGE E. GROLEAU, MD
FREDERICK J. HATEM, MD
JAMES A. STERLING, MD
JOHN C. HYLE, MD
J. PARRAN JARBOE, MD
HERBERT H. LEIGHTON, MD
JULIUS LOEBL, MD
KARL F. MECH, MD
HERMAN C. MAGANZINI, MD
ROLANDO A. NAJERA, MD
WILLIAM R. O'ROURKE, MD
WILLIAM A. PILLSBURY, MD
HAROLD B. PLUMMER, MD
ABDUSSAMED SAMADI, MD
JOHN F. SCHAEFER, MD
JOHN SMITH, MD

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

This committee, with its interested progressive members and subcommittees, has met every other month and many worthwhile projects have been pursued. A representative from the Faculty's Committee on Emotional Health and one from the Regional Medical Program have continued to serve on the committee and have brought much valuable information to the meetings.

A suggestion was received by the committee regarding an opinion on dividing it into two committees, since its charge, as set forth in the Bylaws, is so extensive. The matter was considered and it was unanimously agreed that since the committee's primary responsibility is to coordinate the activities of its many subcommittees, such a division would not be practical because of the overlapping of the various functions covered by this threefold committee. A letter was sent to the Bylaws Committee to this effect.

The representative from the Regional Medical Program reported at each meeting on the projects that have been funded in Maryland and on the position of hospital directors of medical education that have been appointed or are being considered. Continuing education seminars have been held by the RMP with emphasis placed on directors of continuing medical education. Meetings have been held with the chairman of the MEDIC Subcommittee to discuss the possibility of the network being used by the RMP. No decision has been reached to date.

Several activities of the Emotional Health Committee were reported, among which was the lack of facilities in Maryland for emotionally disturbed children and adolescents. The Child Welfare Subcommittee and this parent committee are extremely concerned about this situation. The problem is under intensive study by the Emotional Health Committee. Also, a decision was made not to recommend a change in the Guidelines for Therapeutic Abortion to the effect that all pregnant girls 15 years of age and under should be given a psychiatric evaluation.

In November 1969, a Viral Symposium was held in the Faculty building, cosponsored by the Faculty and the National Communicable Disease Center. This was an all-day program with nationally prominent speakers. The attendance, practically all physicians, was over 100. The program was excellent and there was good audience attention.

Although there is no longer a Speakers Bureau under this committee, three requests were filled for speakers for component medical society meetings.

Resolutions on the hazards of smoking were received from the State Board of Education requesting that the Faculty do whatever possible toward the implementation of these resolutions. An ad hoc committee, after due consideration, drew up a resolution and statement that was recommended to the Executive Committee and approved as Faculty policy.

The Maryland Chapter of the American Cancer Society indicated it would like to have some liaison with the Medical and Chirurgical Faculty on its Professional Education Committee. Since there is no longer a Cancer Subcommittee and because the activities of the Regional Medical Program in the area of cancer and the interest of this committee are similar, it was agreed that the representative from the Regional Medical Program on this committee serve as a liaison.

Both the Cancer and Diabetes Subcommittees were discontinued as it was agreed that having subcommittees for individual diseases could lead to an unlimited number

and become most cumbersome. Any problems regarding specific diseases will be considered by this parent committee. The Medical and Chirurgical Faculty has endorsed an annual Diabetes Detection Drive with the understanding that local components would be free to implement this as they wished.

Subcommittee on Airport Medicine

No actions have been taken on the status of the medical facilities at Friendship Airport by this subcommittee, due to the uncertainty of its sale to the state by the City of Baltimore. However, the latest information is that there is to be a combined ownership. At present, there are 3,000,000 passengers a year who pass through the airport and it is expected there will be 9,000,000 by 1980. These figures do not include visitors and personnel of the airlines. There is a definite need for adequate medical facilities. It is hoped in the near future, when the ownership is settled, that the Faculty will make a recommendation regarding the necessary medical facilities.

Consideration has been given to the large number of fatalities in small plane accidents where alcohol has been involved. The FAA is very active in reviewing this problem and it is recognized that there are undoubtedly a great many nonfatal accidents due to alcohol. It was felt this problem involved three subcommittees: Airport Medicine, Alcoholism, and Traffic Safety. Each of the subcommittees is studying the matter, and a letter will be sent to the FAA with recommendations.

Subcommittee on Alcoholism

Several programs have been presented over the MEDIC Network under the auspices of this subcommittee. A motion was passed that the Faculty urge the Baltimore Area Council on Alcoholism to have a knowledgeable physician present at gatherings, where alcoholism is the main topic, to fully present the concept that alcoholism is a disease. Members of the subcommittee have participated in staff and other hospital and medically oriented meetings to discuss the problem and treatment of alcoholism. It is felt there has finally been a real break-through in reaching the general hospitals regarding the treatment of alcoholism. Through the efforts of a member of this subcommittee and others, there is now an ambulance service for mentally disturbed patients, including alcoholics, in Baltimore city.

A member from the Council on Mental Health of the AMA attended one of the subcommittee meetings and was greatly impressed by the progressive activities and advances that have been made in Maryland in the treatment of alcoholism, and noted that this state could well serve as a model for other states.

The subcommittee recommended support of an increase over last year in the Governor's budget for funds earmarked for alcoholism programs. Also, it has recommended that private rehabilitation units be licensed in order to have payment included in Blue Cross/Blue Shield.

Joint Anesthesia Study Subcommittee

A request was received some time ago that a Joint Anesthesia Study Committee be established on a statewide basis. There has been one in Baltimore city for several years and it has proven quite worthwhile. A chairman was appointed and sent letters regarding willingness to furnish necessary information for a study committee to all hospitals in Maryland, excluding Baltimore city, Prince George's and Montgomery counties. In view of the limited number of affirmative replies received regarding the submission of necessary information and that from experience in this area it was felt only 50% of those would cooperate, it was decided that for the moment such a subcommittee not be established. However, the programs for the city committee meetings are sent throughout the state and can be heard over MEDIC. If anything further develops in this matter, the appointment of a subcommittee will be reconsidered.

Child Welfare Subcommittee

Council approval was received for this subcommittee to look into a program for hearing and vision screening of preschool children in Maryland. This would be similar to the program in Minnesota which has received wide publicity throughout the country. An ad hoc committee was appointed and received approval of a program in Maryland from the Maryland ENT Society, the Maryland Ophthalmological Society, and the Maryland Chapter of the Academy of Pediatrics. The ad hoc committee was composed of representatives from the Academy of Pediatrics, Maryland Society for the Prevention of Blindness, the ENT Society, Health Departments, and several audiologists. After numerous meetings and an in-depth study of all the many phases of such a program, which would be conducted primarily by volunteers, it was agreed that a nonprofit organization be formed with a Board of Directors consisting of four members appointed by the Faculty and three members appointed by the Society for the Prevention of Blindness. Limited seed funds are being made available from the money left from the Mass Measles Campaign in 1968. Definite plans are now being made for the formation of a nonprofit organization and the program no longer will be under the Child Welfare Subcommittee. This organization will be called HAVES (Hearing and Vision Early Screening).

The controversial sex education program in the schools in Maryland was studied, and after careful consideration a proposed policy was recommended. Council approval was received and a Faculty policy statement was formulated.

The state-wide immunization program for rubella was given much study by the Steering Committee on Immunization Projects, composed of the members of the Child Welfare Subcommittee and representatives of the health departments. Guidelines were established, which have been adopted by the National Communicable Disease Center and are being used throughout the country. Also being studied by this Steering Committee is a uniform immunization schedule for children in Maryland. At present the State Health Department, City Health Department, and Academy of Pediatrics each has a different recommended schedule.

Subcommittee on Chronic Respiratory Diseases

A successful seminar, cosponsored by the Medical and Chirurgical Faculty, the Maryland Academy of General Practice, and the Maryland Tuberculosis Association was held. Taken under study was the question of who, other than physicians, could do tuberculin testing. An opinion was received from the Nursing Liaison Subcommittee of the Faculty to the effect that registered nurses and licensed practical nurses could perform this procedure, but that unlicensed lay technicians should not be permitted to function in this manner. This opinion was forwarded to the City and State Health Departments and to the Maryland TB Association. It was also noted that since the closing of the TB Division of the Baltimore City Hospitals there has been a greater problem than ever in the follow-up of tuberculosis patients.

Subcommittee on Maternal Welfare

This subcommittee, as well as the Emotional Health Committee, considered the proposed change in the Guidelines for Therapeutic Abortion to the effect that all pregnant girls 15 years of age and under be given a psychiatric evaluation. After much discussion and after referral to Council, it was agreed that there should not be any changes made in the Guidelines for the present.

The subcommittee members endorsed and testified in favor of the bill now in the State Legislature abolishing the law regarding therapeutic abortion, leaving the decision to the woman and her physician. However, it is felt that there must be some control of possible unethical procedures and this should be by the Commission on Medical Discipline.

The reporting form for hospitals on perinatal mortality was reviewed and recommendations made. The subcommittee endorsed the concept of a course in sex education and family life being taught in the public schools, subject to review by appropriate authorities. As stated in the Child Welfare Subcommittee report, this was incorporated in a Faculty policy statement.

Council approval was received to send a letter to Maryland hospitals asking them to send in case reports on perinatal deaths. Many case reports have been received and these are being processed by the Health Departments and the Ad Hoc Committee on Perinatal Mortality which is under this subcommittee.

Subcommittee on Continuing Medical Education (MEDIC)

An educational program was scheduled for the 1969-1970 year over MEDIC. There is an increasing interest in the network with it being used as part of Baltimore City's National Disaster Plan, Perinatal Conferences, Legislative Committee meetings, broadcasting of the meetings of the city's Joint Anesthesia Study Committee, and calls from hospitals and individual physicians to the Faculty library. There are regular pediatric and medical grand rounds broadcast, as well as weekly replays of the programs presented each Friday.

Members of the Faculty were notified of the opportunity to have a MEDIC speaker installed in their offices, and several have done so. The Regional Medical Program is looking into the possibility of sharing the use of the network. The members of the Maryland Chapter of the Academy of General Practice use MEDIC as a source of credits. The subcommittee passed a motion, which was approved by the Postgraduate Committee, to make an effort to persuade hospitals to give credit for listening to scientific MEDIC programs in lieu of attending staff departmental meetings.

Approval is requested by the House of Delegates on the following recommendation, which was approved by the Postgraduate Committee:

That the MEDIC Network be continued and that such funds be appropriated to the extent needed to finance the operation of the system for a five-year period in order to produce stability and enable proper planning of programs of desired quality. If this action is not deemed acceptable for a five-year period, it is recommended that said funds be made available for the year 1970-71, during which time other sources of maintenance will be sought.

Subcommittee on the Medical Aspects of Sports

Three ad hoc committees were appointed for the purpose of (a) setting up guidelines for follow-up care of abnormalities found on sports physicals, (b) to study the concept of a central registry for reporting sports injuries, and (c) to outline sports trainers curriculum for community colleges. A form for the follow-up procedure for participation in sports was drawn up, received approval by the Faculty and State Board of Education, and is being used as a pilot study in some areas of the State.

A curriculum for sports trainers was drawn up and, after receiving Faculty approval, is now in effect at the Catonsville Community College. The problem of a central registry for reporting sports injuries in the secondary schools is still under study.

The third annual Seminar on the Medical Aspects of Sports, cosponsored by the Faculty and the Catonsville Community College, was held in December 1969. This was most successful and completely self-supporting. A similar seminar is now being planned for December 1970.

Subcommittee on Traffic Safety

The Governor's Safety Legislation Package for the 1969 State Legislature was passed, which included the expressed consent law. This subcommittee was very active in having this legislation enacted. In the 1970 State Legislature, a bill has been introduced to the effect that a statement be included on license renewals about willingness to take a breathalyzer test. This subcommittee has reviewed the proposed bills regarding traffic safety being introduced in the current session of Legislature, and has made appropriate recommendations for support by the Faculty.

An issue of the *Maryland State Medical Journal* in the near future will be devoted to traffic safety. The Bylaws of the Faculty changed the charge to the Occupational Health Committee to include environmental health. At the request of the chairman of that committee, a representative of the Traffic Safety Subcommittee was appointed to serve as a liaison representative on the former committee.

There will be one more meeting of the Committee on Postgraduate Education, Preventive Medicine, and Public Health between the writing of this report and the meeting of the House of Delegates. Actions taken at that time will be included in the next annual report.

* * *

This large committee with its many active productive subcommittees has accomplished much during the past year, both for the profession and for the public. I take this opportunity to express my sincere appreciation to the chairman of each subcommittee and its members for their many hours and efforts devoted to making this a successful year for our committee.

Respectfully submitted,

JOHN WHITRIDGE, JR., MD, *Chairman*
TIMOTHY D. BAKER, MD
JOHN B. DEHOFF, MD
ROBERT E. FARBER, MD
KARL M. GREEN, MD
FREDERICK J. HELDRICH, JR., MD
JOHN H. HIRSCHFELD, MD
D. FRANK KALTREIDER, MD
MILTON B. KRESS, MD
JULIUS LOEBL, MD
WILLIAM J. PEEPLES, MD
LOUIS L. RANDALL, MD
CALBERT T. SEEBERT, MD
RAMSAY B. THOMAS, MD
LOUIS W. TINNIN, MD
JOSEPH B. WORKMAN, MD
BRUCE E. STREM, PhD, *Advisory Member*

Subcommittee on Airport Medicine

Julius Loebl, MD, *Chairman*
Donald Barrick, MD
James E. Toher, MD
John B. De Hoff, MD
Aris T. Allen, MD

Subcommittee on Alcoholism

John H. Hirschfeld, MD, *Chairman*
Conrad B. Acton, MD
Stanley J. Bociek, MD
Irene L. Hitchman, MD
Harry F. Klinefelter, MD
Roland T. Smoot, MD
Irving J. Taylor, MD
Richard H. Anderson, MD
Edmund B. Beacham, MD
John R. Davis, MD
Isadore Kaplan, MD
Leonard M. Lister, MD
Abraham M. Schneidmuhl, MD
Maxwell N. Weisman, MD

Subcommittee on Child Welfare

Karl M. Green, MD, *Chairman*
John A. Grant, MD
Lawrence C. Pakula, MD
Benjamin D. White, MD
Joseph J. McDonald, MD
Richard C. Lang, MD
Murray M. Kappelman, MD
Robert E. Yim, MD
Charles E. Wright, MD
Margaret L. Sherrard, MD
R. M. N. Crosby, MD

Subcommittee on Chronic Respiratory Diseases

Milton B. Kress, MD, *Chairman*
Warde B. Allan, MD
Otto C. Brantigan, MD
A. Murray Fisher, MD
Meyer W. Jacobson, MD
John E. Miller, MD
Edmund G. Beacham, MD
Robert E. Farber, MD
John H. Hirschfeld, MD
Elliott Michelson, MD
William J. Peeples, MD

Subcommittee on Maternal Welfare

D. Frank Kaltreider, MD, *Chairman*
J. Tyler Baker, MD
John S. Haught, MD
Mervyn L. Carey, MD
Edwin R. Ruzicka, MD
Herbert L. Yousem, MD
George H. Davis, MD
Rafael Garcia-Bunuel, MD
Hugh B. McNally, MD
J. King B. E. Seegar, Jr., MD
Jonas R. Rappeport, MD

Ad Hoc Committee on Perinatal Mortality (of the Maternal Welfare Subcommittee)

J. King B. E. Seegar, MD, *Chairman*
George H. Davis, MD
Richard C. Lang, MD
Edwin R. Ruzicka, MD
Rafael Garcia-Bunuel, MD
Joseph J. McDonald, MD

MEDIC Subcommittee

Frederick J. Heldrich, MD, *Chairman*
Edmund G. Beacham, MD
Daniel Bakal, MD
George J. Weems, MD
Alberto Nahum, MD
Carl J. Houmann, MD
Julius Krevans, MD
Arthur T. Keefe, MD
Ralph Weber, MD
Harry Beck, MD
William Schuman, MD
Frederick Johnson, MD
James D. Carr, MD
Leon Sheer, MD
Robert E. May, MD
Pietro U. Capurro, MD
Donald Roop, MD
Charles Spencer, MD
David Marine, MD
Sherman S. Robinson, MD
J. Emmett Queen, MD
George M. Simons, MD
R. Lane Wroth, MD
Robert J. Furie, MD
Thaddeus E. Prout, MD
Aubrey Richardson, MD
James Karns, MD
Richard A. Yates, MD
Paul Huffington, MD
Edwin J. Jensen, MD
William Newman, MD
Emidio A. Bianco, MD
William C. Mulford, MD
Wilson Grubb, MD
William Stewart, MD
James A. Sterling, MD

Subcommittee on Medical Aspects of Sports

Ramsay B. Thomas, MD, *Chairman*
James W. Banks, MD
Fred M. Johnson, MD
John M. Krager, MD
Robert G. Brewer, MD
G. Overton Himmelwright, MD
Herman C. Maganzini, MD

Subcommittee on Traffic Safety

Timothy D. Baker, MD, *Chairman*
Ruth W. Baldwin, MD
Solomon E. Barr, MD
Rudiger Breitenecker, MD
George J. Cohen, MD
John E. Gessner, MD
Irene L. Hitchman, MD
Paul V. Joliet, MD
Howard F. Kinnamon, MD
Perry Stearns, MD
Robert J. Wilder, MD

PROFESSIONAL MEDICAL SERVICES COMMITTEE

Mr. President and Members of the House of Delegates:

This committee is still involved in determining whether or not fee schedules should be developed and publicized or the present policy of the Faculty that this not be done should be continued. A recommendation has been made to the Council suggesting that data be obtained and filed in the Faculty office for reference purposes, but this was rejected by the Council.

Discussions have taken place periodically with Blue Shield representatives about the forms in use through

Medicare. As a result of these discussions, modifications were made in The Explanation of Benefits for Medicare Beneficiaries form.

The committee has started to give consideration to methods of delivery of health care services.

Also considered by the committee were fee payment schedules under Medicaid and the status of the Revision of Workmen's Compensation Schedule.

Respectfully submitted,
GEORGE H. GREENSTEIN, MD, *Chairman*
LEON BERUBE, MD
STUART M. CHRISTHILF, MD
WORTH B. DANIELS, MD
JOHN R. DAVIS, MD
EDWARD DITTO, MD
LEX B. SMITH, MD
CHARLES EARL HILL, MD
JOHN F. HOGAN, JR., MD
THOMAS HUNT, MD
ROBERT W. JOHNSON, III, MD
WATSON KIME, MD
BENJAMIN S. MILLER, MD
STANLEY N. YAFFEE, MD
JOHN E. MILLER, MD
WILLIAM A. MOSBERG, JR., MD
HARRY G. RANDALL, II, MD
MAURYCY SILBER, MD
SALVATORE J. DEMARCO, III, MD
THEODORE E. STACY, JR., MD
ROBERT T. THIBADEAU, MD
EDWIN H. STEWART, MD
WILLIAM A. TYSON, MD
FRANK WEAVER, MD
ALBERT J. WEISS, MD
MORRIS J. WIZENBERG, MD
DONALD O. WOOD, MD
H. BERTON MCCAULEY, DDS

COMMITTEE ON PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The registration at the 1969 Annual Meeting was the highest of any meeting of the Faculty, 1,508, of which 880 were physicians including 65 residents and interns. All scientific sessions were very well attended and many favorable comments were received about the high quality of the program. Again, an excellent report was given by the Medical Exhibitors Association, and the few complaints from the exhibitors were minor. The Health Evaluation program was held for the sixth consecutive year and 590 persons took the tests. This feature of the Annual Meeting continues to be well patronized by many members taking advantage of this opportunity provided by their fellow members.

The 1969 Semiannual Meeting was held at the Hotel Hershey in Hershey, Pennsylvania and proved most successful. While the actual registration was not as high as at some of the previous Semiannual Meetings, the attendance at the scientific sessions and social functions was much greater. Many favorable comments were heard about the facilities at the Hotel. The Woman's Auxiliary cooperated by arranging a "Surprise Fun Night". Members of the Faculty, their wives, and families participated.

Plans and arrangements for the 1970 Annual Meeting are complete. It is felt an outstanding program, with prominent out-of-state speakers, has been scheduled. The medical and surgical grand rounds, which have proven so popular for the past few years, have again been included in the program. All available technical exhibit space has been sold and the income from this will be slightly higher than in 1969. However, it is practically certain expenses involved with the meeting will be higher due to the general economic conditions. The response for scientific exhibit space was very good and some applications were not accepted due to limited facilities in the meeting hall. All scientific exhibits are from Maryland physicians.

An innovation this year will be an Art and Hobby Exhibit, sponsored by the Medical and Chirurgical Faculty and the Woman's Auxiliary. Also, the Faculty is cooperating with the Auxiliary in sponsoring an International Night.

The annual Presidential Reception and Banquet will be held at the Blue Crest North with dancing during and after dinner. A Hospitality Night, which was held for the first time in 1969, will again be held this year with all members and their wives invited as guests of the Faculty. At the annual Round Table Luncheon this year, in addition to the usual scientific subjects discussed, there will be meetings of seven medical alumni groups. The response to the latter already has been very good. The Health Evaluation Tests will again be available for those attending the Annual Meeting. The many procedures and details connected with this valuable benefit of membership in the Faculty are being developed and carried out by a subcommittee composed of members of the Faculty and paramedical groups.

Our committee extends its appreciation to the many members of the Faculty, the Woman's Auxiliary, and Faculty staff for their able assistance and cooperation in planning and carrying out the plans for the Annual and Semiannual Meetings. To all who have volunteered so many hours for arranging and processing the Health Evaluation Tests we wish to express our special thanks.

Respectfully submitted,
DEWITT E. DELAWTER, MD, *Chairman*
ARLIE R. MANSBERGER, JR., MD
JOHN B. DE HOFF, MD
WILLIAM L. STEWART, MD
ERNEST B. NUTTALL, DDS

Subcommittee on Exhibits
ARLIE B. MANSBERGER, JR., MD
JOHN B. DE HOFF, MD
RICHARD R. CRANE
GORDON WEHRLE

PUBLIC RELATIONS COMMITTEE

Mr. President and Members of the House of Delegates:

Three sessions of this committee were held during the year. Items discussed included health manpower and the shortages existing in this area; school health councils on a state and local level; public speaking seminars; medical assistant seminars; foreign interpreters for patients, and many other subjects.

A seminar on public speaking was scheduled for the next presidential year and is similar in content and approach to other, previously held seminars. These have been extremely successful and no doubt this one planned will be as well.

The Woman's Auxiliary has cooperated wholeheartedly with the committee in setting up a list of foreign interpreters for use of patients who can speak no English. This is being constantly updated, and is available through all hospitals in Maryland, as well as the Faculty office and other sources.

The Citizen Award Program was recommended and adopted by the Council. This is a mechanism to recognize lay persons who contribute much to the health of individuals and the community. To date, three awards have been made through component medical societies —three more are being prepared. This has resulted in favorable publicity being given to those individuals

receiving the awards, as well as to the medical profession on a local and state level.

The committee is constantly being made aware of "unfavorable" newspaper publicity, over which very little influence can be exercised. With this in mind, it was felt that a concentrated effort should be made to bring to the public's attention the positive things the Faculty is doing and has done.

The committee recommended to the Council employment of a public relations consultant for the Semi-annual and Annual Sessions. This was approved. However, a disappointing amount of publicity was obtained at both of these meetings. The committee will again reconsider this problem and attempt to find some solutions, if there are any.

This year the medical assistant seminars, so successful in the past, have been scheduled through the state so as to make it easier for office assistants to attend. One was held in Hagerstown for the Western part of the state; and another in Salisbury for the Eastern Shore. Additional sessions are planned for the Metropolitan Baltimore area and for the South-Central and Southern districts.

Still under active consideration is a joint venture with the Hospital Council, Dental, Pharmaceutical and other groups for preparation of pamphlets that would be distributed by all groups. Such a pamphlet would involve the entire gamut of health care costs and attempts to explain the reasons for the cost of quality health care. This will be pursued further during the next presidential year.

In closing, it is pointed out that the best public relations efforts are those put forth by physicians, their wives, their office assistants, and related persons, in their everyday lives. It is important that positive efforts be made with the communications media, but all of the favorable publicity in the world cannot undo the hard feelings that inept handling of patients creates.

Respectfully submitted,
RICHARD A. YOUNG, MD, *Chairman*
MANNING W. ALDEN, MD
ROBERT B. GOLDSTEIN, MD
JAMES M. HITZROT, II, MD
WALTER E. JAMES, MD
FRANK Y. JAGGERS, MD
J. PATRICK JARBOE, MD
CLAYTON NORTON, MD
E. RODERICK SHIPLEY, MD
BERNARD GORDON, DDS
EARL M. BEARDSLEY, MD
MRS. H. LEONARD WARRES

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Reference Committee met on Thursday, February 26, 1970 and considered the three resolutions which had been submitted. Those members of the Faculty who had an interest in these resolutions were present, and a thorough discussion was conducted. After due consideration, the committee makes the following recommendations:

Resolution 1A/70

Submitted: August 12, 1969
Introduced by: 31 members of the Baltimore City Medical Society
Subject: Provision of Ambulatory Diagnostic Benefits by Insurance Carriers, either in the hospital or private office

Whereas, Medical diagnosis is an integral part of the practice of medicine and diagnostic services are physicians' services; and

Whereas, The provision of the so called "pre-admission testing" by Blue Cross Plans involves provision of diagnostic medical services to ambulatory patients; and

Whereas, Provision of pre-admission testing under Maryland hospital care insurance limits the site of service to the hospital; and

Whereas, These restrictions inhibit attending physicians in selecting where and to whom to refer patients for these medical services and does not allow patients freedom of choice; and

Whereas, These restrictions discriminate against the independent practice of Radiology by Radiologists in private offices; and

Whereas, Ambulatory diagnostic benefits are desired by patients, have been recommended by spokesmen for government, labor and management, and will be made available through pre-payment; therefore be it

Resolved, That the Medical and Chirurgical Faculty of Maryland requests and urges Blue Shield/Blue Cross Plans and other insurers of physicians' services to extend ambulatory PRE-ADMISSION TESTING, diagnostic benefits so that they may be performed by PHYSICIANS RECOGNIZED AS QUALIFIED BY THE MEDICAL STAFF OF THE HOSPITAL TO WHICH THE PATIENT EXPECTS TO BE ADMITTED, either in the hospital or private office.

(CAPS PORTIONS ARE ADDITIONS)

This resolution deals with the use of private physician facilities in the provision of Preadmission Testing, *diagnostic studies* whenever possible, rather than using hospital facilities, either as an inpatient or outpatient.

The reasons given in the Whereas portions of the resolution are self-explanatory. There would appear to be no cogent reasons for rejection of this proposed resolution and your Reference Committee recommends its adoption as amended and agreed to by the sponsors.

Resolution 2A/70

Submitted: February 4, 1970
Introduced by: 31 members of the Baltimore City Medical Society
Subject: Urging the Medical and Chirurgical Faculty to recommend to Boards of Trustees and Medical Executive Committees of all Maryland hospitals to take action to discontinue the sale of cigarettes and tobacco in their respective institutions

Whereas, Cigarette smoking cannot be shown to be harmless to anyone, and has been shown to cause an annual mortality of about 300,000 primarily due to pulmonary and cardiac diseases; and

Whereas, The sale of cigarettes through machines and other sources by hospitals could be construed as a disclaimer to the health hazards of smoking; and

Whereas, Such sales by hospitals present difficulties in explaining to patients the harmful effects of tobacco smoking and also present difficulties in encouraging patients to stop this harmful habit; and

Whereas, It is incongruous for hospitals to participate in the sale of cigarettes and indirectly receive revenue from this source while at the same time treating victims of such harmful habits who have lung cancer, pulmonary emphysema and heart disease; and

Whereas, The restricting of such sales of cigarettes by hospitals would be in the best interest of the patients and the public; and

Whereas, The amount of revenue lost by hospitals if such sales of tobacco were stopped would be more than compensated for by the prolongation of life and promotion of healthful living; and

Whereas, The adoption of this resolution presents

no interference with an individual's freedom to do as he wishes, but removes the connotation that hospitals tacitly condone smoking; therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland strongly recommends to Boards of Trustees and Medical Executive Committees of all hospitals in Maryland that they take action to discontinue the sale of cigarettes and tobacco in their respective institutions; and

Resolved, That a copy of this resolution be sent to the Medical Executive Committees and Boards of Trustees of all hospitals in Maryland with the request that they consider adopting the action recommended herein.

This resolution is similar to the policy adopted by many organizations, including the American Medical Association. In addition, the Faculty itself recently adopted a policy statement on the use of tobacco, suggesting that individual physicians discourage people from using tobacco in any form.

Your Reference Committee finds this resolution worthwhile and recommends its adoption and implementation of the Resolved portions.

Resolution 3A/70

Submitted: February 4, 1970

Introduced by: Garrett County Medical Society

Subject: Endorsing the purpose and intent of Article 43-B, establishing the Comprehensive Drug Abuse Control and Rehabilitation Act, and urging implementation and execution of the provisions thereof

Whereas, By Chapter 404 of the Laws of Maryland, 1969, adding a new Article 43-B to the Annotated Code of Maryland, titled "Comprehensive Drug Abuse Control and Rehabilitation Act", the Maryland Legislature created a statutory authority to combat the effects of drug abuse through a statewide program of education, treatment and rehabilitation and for treatment of persons who have become addicts; and

Whereas, This program has not been implemented or executed because of a lack of adequate funds; and

Whereas, THE IMPLEMENTATION OF THIS STATUTE MAY BE CRUCIAL TO CURB the growing problem of drug abuse; now therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland endorse the purpose and intent of Article 43-B and of comprehensive drug abuse control and urge implementation and execution of the provisions thereof by the Legislature.

(CAPS PORTIONS ARE ADDITIONS)

At the time of the Reference Committee hearing, it was not possible to determine the status of the Governor's Budget which includes the sum of $772,435 and provides for a staff of 45 persons in addition to the three members of the authority. However, there is no reason to believe that the State Legislature will reduce this proposed budget. We believe the Governor and the Administration is attempting to implement the Drug Abuse Authority as provided for in the law mentioned in this resolution.

Your Reference Committee recommends adoption of this resolution as amended.

The Chairman wishes to express thanks to the members of the committee who were present and also those members of the Faculty who attended the meeting to present their views in regard to these resolutions.

Respectfully submitted,
Herbert H. Leighton, MD, *Chairman*
Melvin B. Davis, MD
Marvin I. Mones, MD
William L. Mosberg, MD
Raymond M. Yow, MD

SPECIAL COMMITTEES

Ad Hoc Committee on Admission of Patients to Coronary and Intensive Care Units

Mr. President and Members of the House of Delegates:

This ad hoc committee was named by the Executive Committee in late 1968. It held several meetings and made recommendations which were adopted in June 1969.

The recommendations outline guidelines for use of physicians in coronary care units and intensive care units.

Respectfully submitted,
Hilary T. O'Herlihy, MD, *Chairman*
William H. Mosberg, MD
Frank T. Kasik, MD

Advisory Council on Human Trials

Mr. President and Members of the House of Delegates:

This special group was named by the Executive Committee in January 1970 for the purpose of consulting with the Department of Health and Mental Hygiene and other state agencies in various experimental projects that are taking place in Maryland.

It has had several meetings during the current presidential year, but at the time of the Faculty's 1970 Annual Meeting, has nothing concrete to report.

Respectfully submitted,
Thomas B. Turner, MD, *Chairman*
Charles C. Carpenter, MD
John Krantz, PhD
Glen D. Lubash, MD
Howard J. Garber, MD
Robert I. Levy, MD
Matthew Tayback, ScD

Ad Hoc Committee to Consider Consent Forms and Emancipation of Minors

Mr. President and Members of the House of Delegates:

This ad hoc committee held two meetings for the purpose of drawing up sample consent forms for use by hospitals or individual physicians under varying circumstances.

Thirteen forms were developed and distributed to all hospitals in the state. Additional sets have been requested by many hospitals and several individual physicians.

Respectfully submitted,
John F. King, Esq., *Chairman*
Edward F. Cotter, MD
Everett S. Diggs, MD
Brannon Hubbard, Jr., MD

Ad Hoc Committee to Discuss Multiphasic Screening

Mr. President and Members of the House of Delegates:

This ad hoc committee was named by the Council to consider and make recommendations with regard to multiphasic screening. It held several meetings and on June 11, 1969 made a report to the Council which would delay any definitive action for the time being.

The Council has accepted the report but did not disband the committee, instead requested it to reconsider and reevaluate this subject on a six-month basis.

Respectfully submitted,
Manning W. Alden, MD, *Chairman*
Wolcott L. Etienne, MD
Wilmer K. Gallager, Jr., MD
Charles F. O'Donnell, MD

Ad Hoc Committee on Standards for Renal Dialysis and Transplantation

Mr. President and Members of the House of Delegates:

This ad hoc committee was named by the President in August 1969. It held three meetings.

Shortly after its appointment, the local Kidney Foundation established a large group with subcommittees to accomplish the same objectives as this committee. There was considerable discussion as to whether this committee should continue to establish standards since it was felt that only physicians and the medical profession were qualified to develop medical standards. However, it was agreed that this would merely be a duplication of effort, and that such standards, when established by the Kidney Foundation committee, should be reviewed by the ad hoc committee.

There was some discussion of funding dialysis programs and it was agreed that the Department of Health and Mental Hygiene would undoubtedly be the body to consider such funding.

It was suggested that Mr. Sargeant be asked to serve on the Legislation and Public Information Committee established by the Kidney Foundation in order to have a direct liaison between the State Legislature and efforts of this committee.

It was agreed that this committee should remain in existence for the purpose of reviewing and approving drafts of the standards and ethics to be developed by committees of the Kidney Foundation. Otherwise, no further action is contemplated.

Respectfully submitted,
WILLIAM G. ESMOND, MD, *Chairman*
C. THOMAS FLOTTE, MD
ROBERT LEVY, MD
JOHN D. YOUNG, MD
J. B. ZACHARY, MD

TREASURER

Mr. President and Members of the House of Delegates:

An audit of the records of the Treasurer of the Medical and Chirurgical Faculty of the State of Maryland for the year ending December 31, 1969 is attached to the end of this report.

The other matter is the budget. The 1970 budget was very carefully worked out by the Budget Committee. We received estimates from everybody involved, as to the cost for the present year and the coming year. We have carefully considered these before formulating the budget.

This was taken to the Executive Committee and questioned carefully there. As a matter of fact, we went back and called in representatives from several departments such as the Journal, the Library and so forth, and then after full deliberation took it to the Council and it has been accepted by the Council.

You will note it is a deficit budget. We feel, however, for this year we can make out with this deficit budget and have to see what we can forecast for the coming year and if further funds are necessary we will make the case at the Semiannual Meeting.

1970
ESTIMATED EXPENDITURES

	Budget 1969	*Actual through November*	*Budget 1970*	
Auditing	$ 2,000.00	$ 2,052.00	$ 2,100.00	
Legal	5,000.00	6,449.82	7,000.00	
Contributions	700.00	700.00	700.00	A*
Fuel	2,000.00	1,437.10	2,000.00	
Gas, Electricity, Water	5,000.00	4,877.42	5,000.00	
Telephone & Telegraph	5,000.00	5,529.66	5,000.00	
Postage	6,500.00	7,525.53	7,500.00	
Household & Janitorial	1,600.00	2,098.76	2,000.00	
Property Maintenance	3,000.00	3,795.48	3,500.00	
Insurance	2,100.00	1,977.84	2,100.00	
Equipment Rental	4,000.00	3,236.98	4,000.00	
New Equipment	1,500.00	685.00	1,000.00	
Equipment Maintenance	1,000.00	825.15	1,000.00	
Stationery & Supplies	4,000.00	3,131.94	4,000.00	
Salaries	184,718.00	162,766.82	193,242.00	B*
Social Security	7,619.00	6,309.40	8,500.00	
Unemployment Compensation	1,000.00	185.79	1,000.00	
Employee's Insurance Program	3,000.00	3,622.42	4,000.00	
Employee's Pension Program	10,000.00	12,008.43	10,000.00	
Supplementary Hours Exp.	2,500.00	2,682.20	2,500.00	
Travel	7,500.00	6,253.95	7,500.00	C*
Printing	4,500.00	3,964.16	4,500.00	
Legislation	5,000.00	4,199.01	5,000.00	D*
Library	5,000.00	3,763.87	5,000.00	E*
Journal Expense	85,000.00	89,901.37	85,000.00	
Annual & Semiannual Meetings	25,000.00	26,738.46	25,000.00	
Presidential Fund	1,000.00	324.50	1,000.00	
Woman's Auxiliary	1,000.00	1,000.00	1,000.00	
Miscellaneous Expenses	3,000.00	2,042.33	3,000.00	
TOTAL	$389,237.00	$370,085.39	$403,142.00	

* See Explanatory Notes

1970
ESTIMATED INCOME

	1969 Through November	*1970 Budget*
DUES		
Baltimore City Medical Society	$ 106,525.00	$ 106,500.00
Counties	127,321.00	127,000.00
Baltimore City Dental Society	1,825.00	1,800.00
	235,671.00	235,300.00
RENTS & SERVICES		
Baltimore City Medical Society	26,000.00	26,000.00
Board of Medical Examiners	5,150.00	6,300.00
Maryland League for Nursing	385.00	420.00
Med-Chi Insurance Trust	11,475.00	12,000.00
Other	150.00	–0–
	43,160.00	44,720.00
INVESTMENT INCOME		
Restricted Fund Earnings	4,244.19	4,000.00
Short Term Interest	9,983.93	9,000.00
	14,228.12	13,000.00
MEDICAL JOURNAL	70,871.17	77,000.00
ANNUAL MEETING	19,029.30	19,000.00
OTHER	2,851.33	2,000.00
TOTAL	385,810.92	391,020.00

Notes on Proposed Budget:

A. *CONTRIBUTIONS:* Student American Medical Association:

National Chapter	$100.00
University of Maryland Chapter	250.00
National Society for Medical Research	50.00
Miscellaneous	300.00
	$700.00

B. *SALARIES:* Provides for normal salary increments during the 1970 year.

C. *TRAVEL:*

AMA Annual session, Chicago, Ill., June 21-25	Three Delegates
AMA Clinical session, Boston, Mass., Nov. 29-Dec. 2	Senior Alternate Delegate One staff member
Professional Convention Management Association and Medical Exhibitors Association, San Francisco, January 4-7	One staff member
Senior Medical Executives, Chicago, Ill., January 28, 29	One staff member
Congress on Socioeconomics of Health Care, Chicago, Ill., March 20-22	One staff member
Maryland Academy of General Practice, York, Pa., May 9, 10	One staff member
Congress on Medical Ethics, Chicago, Ill., September 18, 19	One staff member
National Congress on Health Manpower, Chicago, Ill., October 22, 23	One staff member

This sum also includes Maryland participation in Southeastern States Hospitality room at AMA Annual and Clinical sessions.

Attendance of Committee and Subcommittee chairmen; as well as Faculty designees at meetings sponsored by AMA and other associated organizations. These are authorized on an individual basis by the Executive Committee.

D. *LEGISLATIVE:*

Operation of First Aid Room	$1,000.00	
Legislative Newsletter (5-6 issues)	3,000.00	
Copies of Legislative bills	300.00	
Legislative Expenses (mileage, meals, etc.)	500.00	
Legislative activity on federal level	200.00	
		$5,000.00

E. *LIBRARY EXPENSES:*

Total, per library budget	$33,500.00	
Less items included in other budget headings (salaries, social security, etc.)	28,500.00	
		$5,000.00

Journal subscriptions, books, binding, etc., are paid for from designated fund income and are, therefore, not included in these figures.

Respectfully submitted,
KARL F. MECH, MD, *Treasurer*

ANNUAL FINANCIAL STATEMENT
of the
Medical and Chirurgical Faculty
of the State of Maryland

March 23, 1970

CERTIFICATE

The Medical and Chirurgical Faculty
of the State of Maryland,
1211 Cathedral Street,
Baltimore, Maryland 21201

Gentlemen:

We have made an audit of the records of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31, 1969. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the balance sheet, together with the supporting statements, present fairly the financial position of the Faculty as of December 31, 1969 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

WOODEN, BENSON & WALTON



THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Baltimore, Maryland

BALANCE SHEET—DECEMBER 31, 1969

EXHIBIT A

ASSETS

General Fund			
Cash			
Maryland National Bank			
Regular checking		25,493.63	
Payroll		4,370.41	
Savings account		246,261.56	
Petty cash fund		400.00	276,525.60
Accounts Receivable			
Membership Dues, journal subscriptions, etc.		17,143.93	
Due from Other Funds			
Med-Chi Insurance Trust Fund	681.45		
Consolidated Fund	21,628.16		
Steiner Fund	7,619.57		
Harvey G. Beck—Lectureship Fund	340.97		
Jesse C. Coggins—Lectureship Fund	163.14		
Educational Fund	6,753.44	37,186.73	54,330.66
Loan Receivable			
Plant Fund			30,000.00
Deferred Charges			
Air Travel		425.00	
Annual meeting		250.00	
Insurance premiums		2,158.98	2,833.98
Total General Fund Assets			363,690.24
Endowment and Other Special Funds			
Consolidated fund—Exhibit A-1			306,246.03
Funded Reserve—Exhibit A-2			17,890.69
Harvey G. Beck—Lectureship fund—Exhibit A-3			3,552.30
Jesse C. Coggins			
Lectureship—Cash—Maryland National Bank		5,516.42	
New Building Fund—Exhibit A-4		195,608.56	201,124.98
George M. Boyer—Lectureship Fund			
Cash—Loyola Federal Savings and Loan Association			5,461.86
Amos Koontz—Memorial Fund—Exhibit A-5			2,772.73
Educational Fund—Exhibit A-6			51,694.52
Medical Annals Fund			
Cash—National City Bank			1,371.49
Henry P. Laughlin—Special Award Fund			
Cash—Loyola Federal Savings and Loan Association			3,310.95

LIABILITIES AND CAPITAL

General Fund			
Liabilities			
Accounts Payable			
Trade		7,361.54	
American Medical Association—dues collected		80,870.00	
Plant Fund		26,365.00	114,596.54
Payroll Taxes			
Withholding			
Federal		409.99	
State		2,253.59	
Old Age Benefit		916.52	
Unemployment insurance			
Federal		382.96	
State		29.97	3,993.03
Designated Fund—Library Account—books and journals			2,830.56
Deferred income—1969 dues			111,683.46
Surplus—Exhibit C			130,586.65
Total General Fund—Liabilities and Capital			363,690.24
Endowment and Other Special Funds			
Consolidated Fund—Exhibit A-1			306,246.03
Funded Reserve—Exhibit A-2			17,890.69
Harvey G. Beck—Lectureship Fund—Exhibit A-3			3,552.30
Jesse C. Coggins			
Lectureship—due General Fund	163.14		
capital—Exhibit J	5,353.28	5.516.42	
New Building Fund—Exhibit A-4		195,608.56	201,124.98
George M. Boyer—Lectureship Fund—Capital			5,461.86
Amos Koontz—Memorial Fund—Exhibit A-5			2,772.73
Educational Fund—Exhibit A-6			51,694.52
Medical Annals Fund—Capital—Exhibit M			1,371.49
Henry P. Laughlin—Special Award Fund—Capital			3,310.95

J. Mason Hundley Memorial Fund			
Cash—Loyola Federal Savings and Loan Association			6,546.61
Lewis H. Steiner Fund—Exhibit A-7			409,987.55
Community Health Project Fund			
Cash—Loyola Federal Savings and Loan Association			5,905.72
Total—Endowment and Other Special Funds			1,015,865.43

J. Mason Hundley Memorial Fund—Capital			6,546.61
Lewis H. Steiner Fund—Exhibit A-7			409,987.55
Community Health Project Fund—Capital			5,905.72
Total—Endowment and Other Special Funds			1,015,865.43

Plant Fund

Cash—Maryland National Bank			144.69
Accounts Receivable—general fund			26,365.00
Fixed Assets—(No depreciation provided)			
1215-1217 Cathedral Street—land—cost		19,118.95	
1209-1215 Cathedral Street			
Land—building—cost	110,635.76		
Improvements—cost	331,525.47	442,161.23	
*Personal Property			
Library books, journals	231,370.00		
Office, library, fixtures, antiques and museum pieces	77,349.48		
Portraits	65,000.00	373,719.48	834,999.66
Total—Plant Fund Assets			861,509.35

Plant Fund

Liabilities		
Jesse C. Coggins—New Building Fund		
—Principal account	44,283.02	
—Income account	750.00	
Loan payable—General Fund	30,000.00	75,033.02
Capital—Exhibit O		786,476.33
Total Plant Fund Liabilities and Capital		861,509.35

Med-Chi Insurance Trust Fund

Cash—Maryland National Bank—checking		24,257.20
Prepaid Insurance premiums		459.25
Total Med-Chi Insurance Trust Fund assets		24,716.45
Grand Total—All Funds		2,265,781.47

Med-Chi Insurance Trust Fund

Liabilities		
Subscriber overpayments		444.30
Edward H. Friend and Company—Consulting actuaries		4,296.01
Mercantile-Safe Deposit and Trust Company—legal and consulting fees		2,670.00
Due general fund for expenditures		681.45
Others		429.92
		8,521.68
Capital—Exhibit P		16,194.77
Total—Med-Chi Insurance Trust Fund Liabilities and Capital		24,716.45
Grand Total—All Funds		2,265,781.47

* The appraised value of portraits as of December 31, 1963 was $65,000, an increase of $51,000 over prior years. All other personal property appraised as of December 31, 1949, with subsequent additions at cost.

STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For Year Ended December 31, 1969

GENERAL FUND

EXHIBIT B

Income			
Dues—Baltimore City Dental Society	1,825.00		
—Baltimore City Medical Society	106,525.00		
—Component Societies	127,261.00	235,611.00	
Rents and Services			
Baltimore City Medical Society	24,057.63		
Others	6,920.00	30,977.63	
Meetings—annual and semiannual exhibits		19,029.30	
Journal—Advertising	76,107.93		
—Subscriptions	1,125.99	77,233.92	
Addressograph service		1,037.96	
Interest on savings accounts		11,666.70	
Miscellaneous		2,027.06	
		377,583.57	
Transfers from Consolidated Fund—income for general purposes—Exhibit F		4,645.67	
Total Income and Transfers			382,229.24
Expenses			
Accounting fees		2,052.00	
Communications—postage, telephone and telegraph		15,518.48	
Contributions		700.00	
Equipment rental and maintenance		4,167.36	
Fuel		1,915.90	
Gas, electricity and water		5,271.00	
Household and janitorial services		2,160.88	
Insurance—general		2,223.53	
—hospitalization		3,784.82	
Journal expenses—printing and commissions		97,423.90	
Legal fees		6,449.82	
Legislature		4,199.01	
Property maintenance		3,919.68	
Meetings—annual and semiannual		27,405.18	
Office supplies		3,889.56	
Purchases of equipment		685.00	
Pension and Major Medical contribution		12,314.09	
Printing		4,218.21	
Salaries		165,792.94	
Social Security tax—employer's portion		7,241.85	
Unemployment Insurance—Federal		382.96	
—State		215.76	
Travel		7,890.66	
Supplementary hours		2,589.24	
Library		4,468.54	
Presidential Fund		324.50	
Miscellaneous		3,095.61	
Woman's Auxiliary		1,000.00	
Total Expenses			391,300.48
Excess of Expenses over Income and Transfers—To Exhibit C			9,071.24

STATEMENT OF SURPLUS

For Year Ended December 31, 1969

GENERAL FUND

EXHIBIT C

January 1, 1969—Balance	139,657.89
Deduction	
Excess of Expenses over Income and Transfers for year ended December 31, 1969—Exhibit B	9,071.24
December 31, 1969—Balance to Exhibit A	130,586.65

BALANCE SHEET—DECEMBER 31, 1969

CONSOLIDATED FUND

EXHIBIT A-1

ASSETS

Income Account			
Cash—The Savings Bank of Baltimore—Exhibit F			
Eugene Cordell Fund	14,087.17		
Special account	38,403.22	52,490.39	
Dividends receivable—Exhibit F		1,836.32	
Investments			
Eugene Cordell Fund—held by Maryland National Bank—Agent—Exhibit F			
Cash	97.73		
Common stocks	7,869.49	7,967.22	62,293.93
Principal Account			
Held by Maryland National Bank—Agent			
Cash		1,127.76	
Investments—at cost			
Bonds			
United States Government and Municipals	3,578.75		
Others	104,744.15	108,322.90	
Stocks		134,501.44	243,952.10
Total—Income and Principal Accounts Assets to Exhibit A			306,246.03

LIABILITIES AND CAPITAL

Income Account			
Liabilities			
Due—General Fund	21,628.16		
—Lewis H. Steiner Fund	1,080.77		
Total—Exhibit F		22,708.93	
Capital—Exhibit E		39,585.00	62,293.93
Principal Account			
Capital—Exhibit G			243,952.10
Total—Income and Principal Accounts Liabilities and Capital—To Exhibit A			306,246.03

BALANCE SHEET—DECEMBER 31, 1969
FUNDED RESERVE

EXHIBIT A-2

ASSETS

Income Account		
Cash—Savings Bank of Baltimore	4,068.81	
Due from principal account—contra	480.34	4,549.15
Principal Account		
Investments—held by Maryland National Bank—Agent		
Cash	359.24	
Common stock	12,982.30	13,341.54
Total—Income and Principal Accounts Assets—To Exhibit A		17,890.69

LIABILITIES AND CAPITAL

Income Account		
Capital—Exhibit H		4,549.15
Principal Account		
Liability		
Due—income account—contra	480.34	
Capital—Exhibit H	12,861.20	13,341.54
Total—Income and Principal Accounts—Liability and Capital—To Exhibit A		17,890.69

BALANCE SHEET—DECEMBER 31, 1969
HARVEY G. BECK—LECTURESHIP FUND

EXHIBIT A-3

ASSETS

Income Account		
Cash—Savings Bank of Baltimore		1,473.20
Principal Account		
Investments—held by Maryland National Bank—Agent		
Cash	109.36	
Common stock	1,969.74	2,079.10
Total—Income and Principal Accounts Assets—To Exhibit A		3,552.30

LIABILITIES AND CAPITAL

Income Account		
Liabilities—Due to General Fund		340.97
Capital—Exhibit I		1,132.23
		1,473.20
Principal Account		
Capital—Exhibit I		2,079.10
Total—Income and Principal Account Liabilities and Capital—To Exhibit A		3,552.30

BALANCE SHEET—DECEMBER 31, 1969
JESSE C. COGGINS—NEW BUILDING FUND

EXHIBIT A-4

ASSETS

Income Account			
Cash—Loyola Federal Savings and Loan Association	28,858.56		
—Maryland National Bank	46.80	28,905.36	
Accrued Interest on Loan to Plant Fund		750.00	
Investments—at cost		63,953.20	93,608.56
Principal Account			
Accounts Receivable			
Due from Plant Fund		44,283.02	
Due from income account—contra		57,716.98	102,000.00
Total—Income and Principal Accounts Assets—To Exhibit A			195,608.56

LIABILITIES AND CAPITAL

Income Account		
Liabilities		
Due to principal account—contra	57,716.98	
Capital (includes $2,571.82 of interest and dividends earned during year)	35,891.58	93,608.56
Principal Account		
Capital		102,000.00
Total—Income and Principal Account Liabilities and Capital—To Exhibit A		195,608.56

BALANCE SHEET—DECEMBER 31, 1969
AMOS KOONTZ—MEMORIAL FUND

EXHIBIT A-5

ASSETS

Principal Account	
Cash—Loyola Federal Savings and Loan Association	2,772.73
Total Principal Account Assets—To Exhibit A	2,772.73

LIABILITIES AND CAPITAL

Principal Account	
Liabilities	None
Capital—Exhibit K	2,772.73
Total—Principal Account Liabilities and Capital—To Exhibit A	2,772.73

BALANCE SHEET—DECEMBER 31, 1969
EDUCATIONAL FUND

EXHIBIT A-6

ASSETS

Principal Account	
Cash—Maryland National Bank—savings account	51,694.52
Total—Principal Account Assets—To Exhibit A	51,694.52

LIABILITIES AND CAPITAL

Principal Account	
Liabilities	
Due to General Fund for expenditures	6,753.44
Capital—Exhibit L	44,941.08
Total—Principal Account Liabilities and Capital—To Exhibit A	51,694.52

BALANCE SHEET—DECEMBER 31, 1969
LEWIS H. STEINER FUND

EXHIBIT A-7

ASSETS

Income Account		
Cash—Savings Bank of Baltimore	31,849.36	
Dividend receivable	738.05	
Total Income Account Assets		32,587.41
Principal Account		
Uninvested cash—Maryland National Bank	1,572.95	
Due from income account—contra	4,079.64	
Due from Consolidated Fund	1,080.77	
Investments—at book value	370,666.78	
Total Principal Account Assets		377,400.14
Grand Total—Income and Principal Account Assets—To Exhibit A		409,987.55

LIABILITIES AND CAPITAL

Income Accounts		
Liabilities		
Due to General Fund for expenditures	7,619.57	
Due to principal account—contra	4,079.64	11,699.21
Capital—Exhibit N		20,888.20
Total Income Account Liabilities and Capital		35,587.41
Principal Account		
Capital—Exhibit N		377,400.14
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A		409,987.55

STATEMENT OF INCOME, EXPENSES AND APPROPRIATIONS
For Year Ended December 31, 1969
CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT D

Income			
Investments—General			
Bonds			
United States Government and municipals	332.69		
Others	4,285.00	4,617.69	
Stocks			
Preferred	423.07		
Common	13,152.28	13,575.35	
Interest on special savings accounts—The Savings Bank of Baltimore		1,716.97	
		19,910.01	
Less—agency fees	879.53		
brokers fees	2,015.55	2,895.08	
Net income—Exhibit F		17,014.93	
Investments—Eugene F. Cordell Fund—Exhibit F			
Stocks			
Common	392.80		
Less—agency fee	23.57	369.23	17,384.16
Interest on savings account—The Savings Bank of Baltimore—Exhibit F			752.79
			18,136.95
Expenses and Appropriations—Exhibit F			
Library purposes		10,748.20	
General Fund purposes		4,645.67	
Lectureship		322.65	
Cordell Fund		3,330.41	19,046.93
Excess of Expenses and Appropriations over Income—To Exhibit E			909.98

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT E

January 1, 1969—Balance—Exhibit F	40,494.98
Deduction	
Excess of expenses and appropriations over Income for year ended December 31, 1969—Exhibit D	909.98
December 31, 1969—Balance to Exhibits A-1 and F	39,585.00

STATEMENT OF RECEIPTS, EXPENSES AND BALANCES
For Year Ended December 31, 1969
CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT F

Fund	Distributive Share (Percent)	Balance January 1, 1969	Income Received During Year			Balance January 1, 1969 Plus Receipts	Expenses				Balance December 31, 1969	
			Savings Account Interest	Investment Income (Distributive Share)	Investment Income (Direct)		Library	Transferred to General Fund (Exhibit B)	Lectureship	Other	Cash Investments and Dividends Receivable	Cash on Deposit
Baker	.65	94.86		96.70		191.56	63.05				128.51	
Barker, Lewellys F.	.39	35.92		58.02		93.94					93.94	
Bowen, Josiah S.	9.17	(96.29)		1,364.26		1,267.97		1,267.97				
Bressler, Frank C.	1.80	(18.90)		267.79		248.89		248.89				
Cordell, Eugene Fauntleroy	3.64	21,904.29	752.79	541.54	369.23	23,567.85				3,330.41	20,237.44	14,087.17
Cowles, Nellie N.	.75	1,062.75		111.58		1,174.33					1,174.33	
Ellis, Charles M.	—	—		2,137.50		2,137.50		2,137.50				
Finney, John M. T.	8.40	5,733.88		1,249.71		6,983.59	1,184.14		150.00		5,649.45	
Frick, William F.	15.02	(157.71)		2,234.59		2,076.88	2,076.88					
Friedenwald, Julius F.	.75	(7.88)		111.58		103.70		103.70				
Harlan, Herbert	.76	295.14		113.07		408.21	63.57				344.64	
McCleary, Standish	.75	35.47		111.58		147.05	83.10				63.95	
Osler Endowment	1.40	409.65		208.29		617.94	13.00				604.94	
Osler Testimonial	7.75	3,863.28		1,153.00		5,016.28	418.50	576.50			4,021.28	
Ruhrah, John	40.79	2,174.67		6,068.50		8,243.17	6,553.22				1,689.95	
Stokes, William Royal	3.09	1,138.25		459.71		1,597.96	292.74				1,305.22	
Trimble, Isaac Ridgeway	2.64	4,051.23		392.77		4,444.00			172.65		4,271.35	
Woods, Hiram	2.25	(23.63)		334.74		311.11		311.11				
	100.00	40,494.98	752.79	17,014.93	369.23	58,631.93	10,748.20	4,645.67	322.65	3,330.41	39,585.00	14,087.17
		To Exhibit E		Totals To Exhibit D			Totals To Exhibit D				To Exhibit E	To Summary

SUMMARY—To Exhibit A-1

Cash		
Individual Accounts—above	14,087.17	
Special Account	38,403.22	
Dividends Receivable	1,836.32	54,326.71
Cordell Fund		
Cash	97.73	
Investments	7,869.49	7,967.22
		62,293.93
Less—Accounts payable to Other Funds		22,708.93
		39,585.00

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
CONSOLIDATED FUND—PRINCIPAL ACCOUNT

EXHIBIT G

Fund	*Purpose*	*Balance January 1, 1969*	*Net Profit on Security Sales*	*Balance December 31, 1969*
Baker	Book on Materia Medica	1,403.50	131.62	1,535.12
Barker, Lewellys F.	Library	842.11	78.97	921.08
Bowen, Josiah S.	General	19,758.69	1,856.83	21,615.52
Bressler, Frank C.	General	3,877.70	364.48	4,242.18
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	7,843.81	737.06	8,580.87
Cowles, Nellie N.	Books on Neurology	1,617.46	151.87	1,769.33
Ellis, Charles M.	General	8,258.46	—	8,258.46
Finney, John M. T.	Books, journals, and lectureships on surgery	18,089.03	1,700.91	19,789.94
Frick, William F.	Maintenance of Frick Library and purchase of books and journals	32,353.14	3,041.39	35,394.53
Friedenwald, Dr. Julius	Maintenance of Friedenwald Room	1,617.47	151.87	1,769.34
Harlan, Herbert	Books on Ophthalmology	1,640.91	153.89	1,794.80
McCleary, Standish	Lectureships and books on Pathology	1,617.47	151.87	1,769.34
Osler—endowment	Permanent endowment for library by request of Dr. Osler	3,011.44	283.49	3,294.93
Osler—testimonial	Medical books and maintenance of Osler Hall	16,691.65	1,569.29	18,260.94
Ruhrah, John	Library books, journals, etc.	87,870.73	8,259.56	96,130.29
Stokes, William Royal	Lectureships and books on Bacteriology or Pathology	6,663.50	625.69	7,289.19
Trimble, Isaac Ridgeway	Lectureship only	5,690.37	534.57	6,224.94
Woods, Hiram	General	4,855.70	455.60	5,311.30
		223,703.14	20,248.96	*243,952.10
			Total per Schedule G 1	*To Exhibit A-1

STATEMENT OF SECURITIES SOLD
During the Year Ended December 31, 1969
CONSOLIDATED FUND—PRINCIPAL ACCOUNT

EXHIBIT G-1

Par Value Shares or Rights	*Description*	*Amount Received*	*Cost*	*Profit or (Loss)*
	Bonds			
	United States Government			
7,000	Treasury Bonds—4¼%—due May 15, 1974	6,181.88	7,039.37	(857.49)
	Common Stock			
165	Pacific Gas and Electric Company	6,133.00	2,230.54	3,902.46
114	Shulton, Inc.	3,241.76	3,824.61	(582.85)
200	General Motors Corporation	16,395.17	1,165.62	15,229.55
200	Pacific Telephone and Telegraph Company	5,939.06	3,466.90	2,472.16
	Stock Rights			
240	Baltimore Gas and Electric Company	4.07	—	4.07
	Fractional Shares			
84/100	Maryland Cup Corporation	40.74	—	40.74
24/100	Shulton, Inc.	10.92	—	10.92
700/1,000	Maryland Cup Corporation	29.40	—	29.40
		37,976.00	17,727.04	*20,248.96
				* Total per Exhibit G

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
FUNDED RESERVE

EXHIBIT H

INCOME ACCOUNT

January 1, 1969—Balance		3,587.67
Additions		
Dividends	742.75	
Interest—United States Government Bonds	70.18	
—Savings accounts	197.35	1,010.28
		4,597.95
Deductions		
Agency fee		48.80
December 31, 1969—Balance—To Exhibit A-2		4,549.15

PRINCIPAL ACCOUNT

January 1, 1969—Balance		12,985.29
Addition		
Sale of stock rights		5.60
Deduction		
Loss on sale of securities		129.69
December 31, 1969—Balance—To Exhibit A-2		12,861.20

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
HARVEY G. BECK—LECTURESHIP FUND

EXHIBIT I

INCOME ACCOUNT

January 1, 1969—Balance		1,213.74
Additions		
Dividends	196.80	
Interest—savings account	74.46	271.26
		1,485.00
Deductions		
Agency fee	11.80	
Reimbursement to general fund for expenditures	340.97	352.77
December 31, 1969—Balance—To Exhibit A-3		1,132.23

PRINCIPAL ACCOUNT

January 1, 1969—Balance	2,079.10
No changes during year ended December 31, 1969	.....
December 31, 1969—Balance—To Exhibit A-3	2,079.10

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
JESSE C. COGGINS—LECTURESHIP FUND

EXHIBIT J

January 1, 1969—Balance	5,267.36
Addition	
Interest—savings account	249.06
	5,516.42
Deduction	
Reimbursement to general fund for expenditures	163.14
December 31, 1969—Balance—To Exhibit A	5,353.28

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
AMOS KOONTZ—MEMORIAL FUND

EXHIBIT K

PRINCIPAL ACCOUNT

January 1, 1969—Balance	2,787.94
Addition	
Interest on savings account	134.79
	2,922.73
Deduction	
Reimbursement to general fund for expenditures	150.00
December 31, 1969—Balance—To Exhibit A-5	2,772.73

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
EDUCATIONAL FUND

EXHIBIT L

PRINCIPAL ACCOUNT

January 1, 1969—Balance		58,633.33
Additions		
Investment income	3,071.53	
Participants payments	13,870.45	
Viral disease symposium	462.50	
Aspect of sports seminar ticket sales	771.50	18,175.98
		76,809.31
Deductions		
Public relations and educational expenses	971.96	
MEDIC network	28,897.91	
Viral disease symposium	697.52	
Aspect of sports seminar	1,300.84	31,868.23
December 31, 1969—Balance—To Exhibit A-6		44,941.08

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
MEDICAL ANNALS FUND

EXHIBIT M

January 1, 1969—Balance	1,331.39
Addition	
Interest on savings account	40.10
December 31, 1969—Balance—To Exhibit A	1,371.49

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
LEWIS H. STEINER FUND

EXHIBIT N

INCOME ACCOUNT

January 1, 1969—Balance		14,582.22
Additions		
Investment income	12,858.05	
Interest on savings account	1,379.33	14,237.38
		28,819.60
Deductions		
Agency fees	673.87	
Reimbursement of general fund for purchase of library books	7,257.53	7,931.40
December 31, 1969—Balance—To Exhibit A-7		20,888.20

PRINCIPAL ACCOUNT

January 1, 1969—Balance		367,960.44
Addition		
Gain on sale of securities		9,439.70
December 31, 1969—Balance—To Exhibit A-7		377,400.14

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
PLANT FUND

EXHIBIT O

January 1, 1969—Balance		768,101.33
Addition		
Assessments		18,375.00
December 31, 1969—Balance—To Exhibit A		786,476.33

STATEMENT OF CAPITAL
For Year Ended December 31, 1969
MED-CHI INSURANCE TRUST FUND

EXHIBIT P

January 1, 1969—Balance			6,013.47
Additions			
Receipts			
Membership Premiums Collected			
Accident, sickness and total disability, etc.	288,541.35		
Blue Cross and Blue Shield	359,339.72		
Business overhead and disability	35,793.53	683,674.60	
Retirement program		6,191.00	
Administration fees		18,557.13	
Interest on securities		6,511.70	
		714,934.43	
Disbursements			
Premiums to various insurance companies	683,674.60		
Salaries	11,475.00		
Fees—legal	4,538.42		
—consulting	2,490.00		
—auditing	300.00		
Postage, stationery and supplies, etc.	2,275.11	704,753.13	
Excess of receipts over disbursements			10,181.30
December 31, 1969—Balance To Exhibit A			16,194.77

WOMAN'S AUXILIARY

Mr. President and Members of the House of Delegates:

Your Woman's Auxiliary appreciates this privilege of reporting to you on the accomplishments of this past year.

We have tried to insure continuity of already existing programs with especial accent on youth and a determination to create a better image of American medicine and thus foster favorable public sentiment.

Through conscientious efforts to support the American Medical Association Education and Research Foundation, we have raised a significant sum of money for medical education and research—more than $6,200. I should like to express to you deep appreciation for your action taken to channel through the Auxiliary AMAERF chairman all funds collected from Faculty members as of November 3, 1969. This will enable us to compete on the same basis with other state auxiliaries credited with medical society donations. We are determined that your altruistic decision to relinquish the honor of presenting this fund at the AMA House of Delegates will not decrease our own independent efforts to raise funds for medical schools and the Student Loan Guaranty Fund.

We have expanded upon our programs for Children and Youth, the committee for which was instituted only last year. One county auxiliary has been exemplary in its involvement in its Child Development Council and work in the Family Life and Sex Education program. Many of our members have been actively working with school and church groups, presenting programs on drug abuse and alcohol. We have continued the battle against violence in movies, TV and radio through visitation to the State Board of Movie Censors and through letters to responsible persons. We have continued to work for representation at the White House Conference on Youth and to date have secured one appointment to a subcommittee.

Our members have responded superbly to the need for more medical and paramedical personnel in many ways. Over and above the financial help of $300 from our state auxiliary treasury allotted to the Future Nurses —Health Career Clubs of Maryland, scholarships and loans are provided by the auxiliaries of Baltimore, Montgomery, Prince George's, Washington, and Wicomico Counties. The Baltimore City auxiliary this year has presented five loans to students, totaling $3,599. The Prince George's County Auxiliary presented three nursing scholarships totaling $1,600 and helped their medical society select winners for three more scholarships. The Allegany County Auxiliary worked very diligently promoting the nine Health Careers Clubs in its county and in producing in cooperation with the Board of Education the second annual Health Fair held March 23, 1970. The Harford County Auxiliary has completed a slide presentation of medical and paramedical careers available in Harford County, along with a tape narration, and has shown it to junior and senior high school students.

Our mental health program this year has been mainly concerned with children. Our members have given financial support to mental hospitals and day care centers for retarded persons; provided transportation for patients to mental health clinics; contributed to "Operation Santa Claus"; given books, toys, toothbrushes and tooth kits to institutions for mentally retarded; shown films to school children on drug abuse and alcohol; and supported their local Mental Health Associations. One auxiliary provided hostesses for the World Federation of Mental Health in Washington, D. C. *M.D.'s Wife* magazine has recognized one Maryland auxilian's role in establishing a day care center for retarded persons and has requested more information for a feature article.

We purchased a filmstrip entitled "A New Look at the Old Sauce", an entertaining cartoon that teaches, not preaches, about the use and abuse of alcohol. Auxilians in Allegany, Harford and Wicomico counties have shown this to school children in their communities and have evoked very favorable responses.

The interest of the auxiliary in legislation has been maintained: Two component auxiliaries have traveled to Annapolis by bus to visit the Legislature and their local representatives. Another auxiliary visited with its county commissioners. Membership in MMPAC is always encouraged; six members of the auxiliary, including the president, attended the national AMPAC workshop in Washington, D. C. on February 28, 1970. The auxiliary is always on the letter-writing alert in behalf of good medical legislation and most recently responded to your "Medical Alert" to oppose House Bills 807 and 403.

Auxiliary action in community health services means recognizing the local community's needs and then doing something constructive about them, oftentimes in cooperation with other existing organizations. Throughout the state we have a fine record of community health services of a widely varying nature. These include participating in a Cardiac Symposium; mailing of tuberculosis Christmas seals; fighting air pollution and litter; cooperating with the Heart Association, American Cancer Society, local hospital auxiliaries, and garden clubs; distributing poison control information, and staffing diabetes detection clinics.

Not only has the auxiliary been pleased to respond to the Faculty's call for representation on the Legislation and Public Relations committees, but the auxiliary president has been privileged to attend seven meetings of the Faculty's Program and Arrangements Committee. She assisted with arrangements for the Semiannual Meeting in Hershey, Pennsylvania, September 1969, organizing an innovation in the program—Auxiliary Fun Night, a well-received evening of entertainment by members of the auxiliary and their families. The auxiliary has also complied with requests of the Program and Arrangements Committee to plan an Art and Hobby Show for the Annual Meeting and to provide hostesses for the exhibitors at the Alcazar.

Great emphasis was placed on increasing our membership. It is an established fact that the greater our number, the more effectively we can serve the Medical and Chirurgical Faculty. The auxiliary is grateful to the Faculty president for his cooperation in our membership drive. His letters to those physicians and their wives who were not auxiliary members procured for us 43 new members to date. Our greatest increase in membership this year has been among the members-at-large—25 new members, bringing our membership in the 10 unorganized counties to a total of 55. Even though we have attracted many new members, due to resignations and moves to out-of-state, our number has remained almost static—942. We recognize a sad illness among physicians' wives—one called APATHY—and we hope you will help us find the cure.

Your auxiliary has had close rapport with the Woman's Auxiliary to the Southern Medical Association through our councilor and vice-councilor. It is noteworthy that several of our Maryland auxiliary members hold positions on the Southern Medical Auxiliary board. Doctors' Day, originally promoted by this southern auxiliary, was observed by each of our component auxiliaries

and by many of our members-at-large. Governor Mandel's proclamation was secured and distributed widely. Besides the use of the red carnation and many social functions to honor our physicians, AMAERF contributions were made, books were purchased, library displays were set up, and niceties extended to patients in many hospitals.

Your auxiliary has promoted international health activities by extending hospitality to foreign medical personnel and by collecting sample drugs, books, used instruments, and clothing for overseas shipment. Names of volunteers have been added to the list of interpreters for foreign-speaking patients. This year, for the first time, in conjunction with the Annual Meeting, the auxiliary chairman for International Health Acitivities planned an educational and entertaining fund-raising evening on April 1 at the Belvedere Hotel. Exhibits of articles collected, hand-out literature, gay posters, an inspiring talk by a Baltimore physician who has served in Vietnam, oriental dances, auction of a piece of sculpture entitled "International Help", a dinner with an international menu, and a fashion show for both men and women were some of the features of the evening. The profit realized will be used to cover shipping expenses of collected articles and to make a significant contribution to a project such as the ship HOPE. The auxiliary is grateful to the Faculty for its approval of this project and for its cooperation in making it a success.

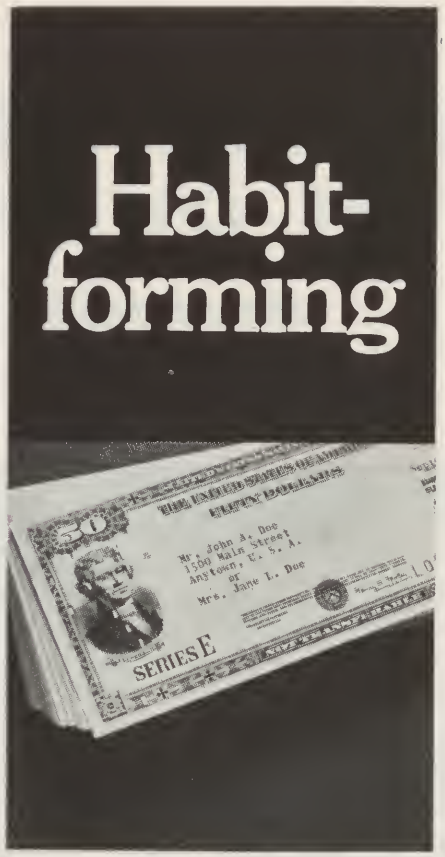
We have kept our membership informed of our goals and accomplishments through two issues of our newsletter, *Hygeia Filiae,* which is also sent to the national auxiliary officers and to leaders in the other 49 state medical auxiliaries. We are appreciative for the opportunity to communicate with the Faculty members through the Auxiliary Page of the MARYLAND STATE MEDICAL JOURNAL.

Due to the generosity of the Medical and Chirurgical Faculty, who has again this year contributed $1000 to the auxiliary, we have not had to raise dues and our finances are in good order in spite of rising costs. The auxiliary is indeed grateful to the Faculty for this expression of confidence in us. We are also indebted to the Faculty for the clerical assistance afforded us by its staff.

Since the Faculty chose for its theme for the Annual Meeting "Medicine Looks to the 70's" and since our accent has been on youth, I chose for the theme of the auxiliary's Annual Meeting "Youth in the Soaring 70's". In keeping with this theme, our keynote speaker was Matthew Debuskey, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine, whose topic, "Generation Without Shadow", was most thought-provoking and enlightening. Also in keeping with our accent on youth, we heard reports at our General Session from the young ladies who are presidents of the Future Nurses—Health Careers Club of Maryland and the University of Maryland chapter of the Woman's Auxiliary to the Student American Medical Association, both of these organizations recipients of our financial assistance and counsel.

The auxiliary has tried to fulfill its objectives to assist the Medical and Chirurgical Faculty in the advancement of medicine and general health and to encourage students to elect medical careers and we fervently hope that the Faculty has found us helpful. We pray that as the auxiliary approaches its 21st year in this new decade, the Faculty and Medicine as they "look to the 70's", can depend on us as physicians' wives to brighten that outlook.

Respectfully submitted,
MRS. WALLACE H. SADOWSKY, *President*



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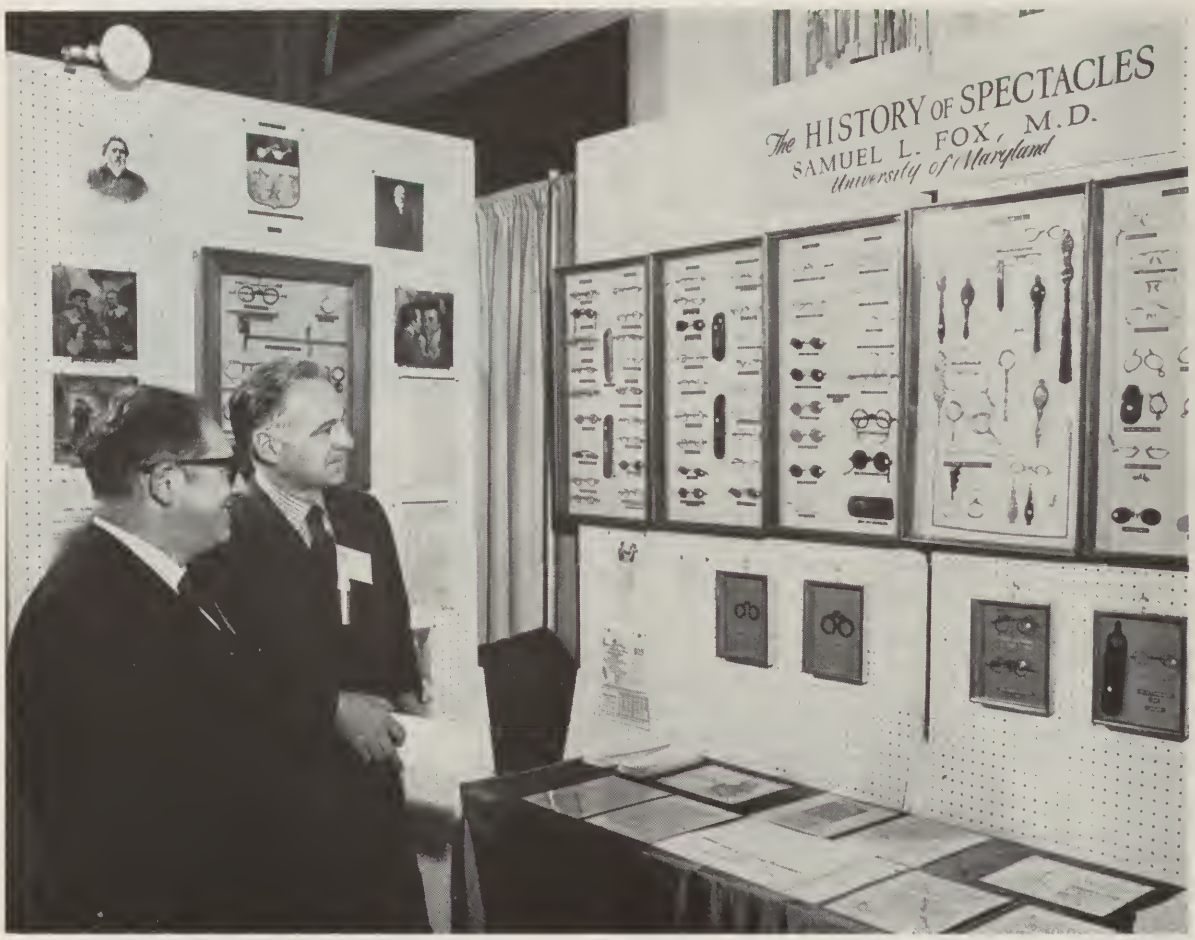
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HIGHLIGHTS—

Awards and Presentations



Samuel L. Fox, MD (left) a Pikesville resident and ophthalmologist at the University of Maryland School of Medicine, discusses his prize-winning exhibit, "The History of Spectacles", with DeWitt DeLawter, MD, of Bethesda, during the Annual Meeting in April. Dr. Fox's display was judged best of all scientific exhibits at the meeting. Dr. DeLawter served as chairman of the Program and Arrangements Committee.

ANNUAL MEETING 1970



Arthur G. Siwinski, MD, of Baltimore (left), receives the past-president's plaque from Russell S. Fisher, MD, president of the Medical and Chirurgical Faculty, at the Annual Meeting in April.



Dr. Fisher presents the Community Service Award plaque to Aris T. Allen, MD (left), an Annapolis general practitioner. Dr. Allen is also Minority Whip (Rep.) in the Maryland House of Delegates. The presentation was made during the Annual Presidential Banquet.



Checks totaling more than $33,000 in contributions to medical schools in Maryland are presented to John Neff, MD (far left), representing The Johns Hopkins School of Medicine, and John Moxley, MD (center), from the University of Maryland School of Medicine. Making the presentation is Russell S. Fisher, MD, president of the Faculty.
Money for the American Medical Association Education Research Foundation was raised with the help of Med-Chi's Woman's Auxiliary.



Accepting the gavel as new president of the Faculty is Henry A. Briele, MD (right), a general practitioner from Salisbury. At left, Russell S. Fisher, MD, out-going president, congratulates Dr. Briele.

MED-CHI SEMIANNUAL MEETING

SEPTEMBER 10, 11, 12

For information on the happenings,

Watch future issues of the Journal

The MEDICAL and CHIRURGICAL FACULTY of the State of Maryland

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your medical faculty at work

by John Sargeant
Executive Director

On Friday, April 3, 1970, the House took the following actions:

1. Elected the slate of officers presented to the Wednesday session;
2. Declined to consider the resolutions sponsored by Prince George's County (*see page 29*);
3. Adopted the following motions offered by the Mediation Committee:
   (a) To rescind the action of the House of Delegates taken in 1962 which was that "Podiatrists should not be on hospital staffs nor engaged in open surgery."
   (b) Adopt the same standards as of January 1, 1970 with respect to Podiatrists as the Joint Commission on Accreditation of Hospitals;
4. Heard a report from the Woman's Auxiliary President on the past year's activities;
5. Adopted Resolution 1A/70 (*see page 79*);
6. Adopted Resolution 2A/70 (*see page 79*);
7. Adopted Resolution 3A/70 (*see page 80*);
8. Adopted the following motions, all under new business:
   (a) That the House urges the Legislative Committee to use every effort to attempt to retain the present legal limits of Podiatric practices.
   (b) That the President of the Faculty appoint an Ad Hoc Committee to investigate all facets of the MEDIC network and render a report to the House of Delegates at the 1970 Semiannual Meeting, with such report being distributed to all House members in advance of such meeting.
   (c) The Faculty directs its members on the Blue Shield Board to work towards elimination of arbitrary restrictions on the number of visits a physician may make in treating his patients.
   (d) Whereas, the Program and Arrangements Committee of the Faculty works long and hard to obtain speakers of national prominence for Annual and Semiannual meetings, both current and past; and

   Whereas, The attendance at some of the meetings of the current Annual Session was embarrassingly small; and

   Whereas, The quality of the various endowed lectureships is endangered; and

   Whereas, The Alcazar's future is somewhat in doubt and its facilities are not what could be considered the most modern and attractive; therefore, be it

   Resolved, That the Program and Arrangements Committee be instructed by the House of Delegates to:

   (1) Explore the possibility of finding a more attractive facility for the location of the Annual Meetings, and

   (2) Explore any necessary methods to increase physical attendance of members and guests commensurate with the quality of the speakers

   (e) The action of the Council be ratified in supporting repeal of all abortion laws in the State of Maryland and that the Faculty be represented at the public hearing in this regard scheduled by the Governor for Wednesday, April 22, 1970, at 2:00 PM.*

   * *Changed to April 23, 1970.*

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Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
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ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Minutes—April and May 1970

The Board of Directors of the Baltimore City Medical Society met on April 14th at 4:30 PM at 1211 Cathedral Street.

The minutes of the March 10th meeting were approved as written.

In view of recent comments regarding the efficiency and effectiveness of the Professional Relations Committee, a general discussion of the functions of the committee took place. The Board felt that the relationships among the Professional Relations Committee, the Med-Chi Mediation Committee and the Maryland Commission on Medical Discipline should be more clearly defined and it was suggested that further information be gathered before any attempt is made to reorganize the Professional Relations Committee. To this end, it was suggested that Lewis P. Gundry, MD, chairman of the Med-Chi Mediation Committee, and John M. Dennis, MD, chairman of the Maryland Commission on Medical Discipline, be invited to the next meeting of the Board to describe their respective committees.

A suggestion was made and approved that all committee work be done through the Society office to ensure continuity of records and communication. It was also urged that whenever possible, the Society secretarial staff should attend the meetings of the committees so that proper transcripts are available.

A question of whether the Bylaws should be amended to require that committee chairmen attend and report at all general meetings of the Society was considered. The idea of compulsory attendance was not favored by the Board but it was suggested that committee reports be carried on the agenda of each meeting and that committee chairmen be encouraged to make a written or oral report as often as possible.

The Board unanimously agreed to send a letter to the Governor urging that he sign the abortion bill recently passed by the State Legislature.

The Board then considered the problem of "Peer Review" and concurred in the recent suggestion from the State Medical Society that each individual component society form a Peer Review Committee. Dr. Classen stated that he would gain further information on the subject of how the committee should operate prior to its selection.

Philip Wagley, MD, reported that he had written to Gordon Walker, MD, asking if he would serve on a committee to investigate the Maryland Artificial Kidney Treatment Fund.

Because of the special meeting of the Council of the Medical and Chirurgical Faculty of the State of Maryland, scheduled for May 12, 1970, the Board agreed to change its next meeting date to Tuesday, May 5, 1970.

There being no further business, the meeting was adjourned at 5:40 PM.

The May 5th meeting of the Board of Directors of the Baltimore City Medical Society was called to order by John N. Classen, MD, at 4:30 PM at 1211 Cathedral Street.

The minutes of the April 14th meeting were approved as distributed.

Under discussion are the various roles of the Med-Chi Mediation Committee, the Maryland Commission on Medical Discipline and the Baltimore City Medical Society Professional Relations Committee in the handling of complaints against physicians. John M. Dennis, MD, chairman of the Maryland Commission on Medical Discipline explained that this body functions as a court and has jurisdiction over all physicians in the state whether or not they are members of the medical society. The investigation of all complaints is carried out by the Med-Chi Mediation Committee. The commission is endowed with the power of subpoena and can take action against a physician

prior to his conviction in court.

The Med-Chi Mediation Committee considers cases referred to it by the commission, the state society, or by a component society. The committee can also institute an investigation if necessary. After investigation, if the Mediation Committee feels that action by the commission is warranted, it can refer, with recommendations, any case to the commission for consideration.

The basic structure, therefore, for handling complaints should be that, if possible, the case should be settled on the component society level. If no agreeable solution can be found or if there is reason to believe that action should be taken against a physician the matter should be referred to the Mediation Committee, and then, if necessary, to the Commission on Medical Discipline.

A recommendation was made and approved that in order to ensure efficiency and continuity, the membership of the Professional Relations Committee should not rotate.

The Board discussed the report of the Med-Chi Policy and Planning Committee concerning the recommendations for reorganizing and revitalizing the AMA. It was agreed to write to the Med-Chi Council urging the adoption of this report as presented.

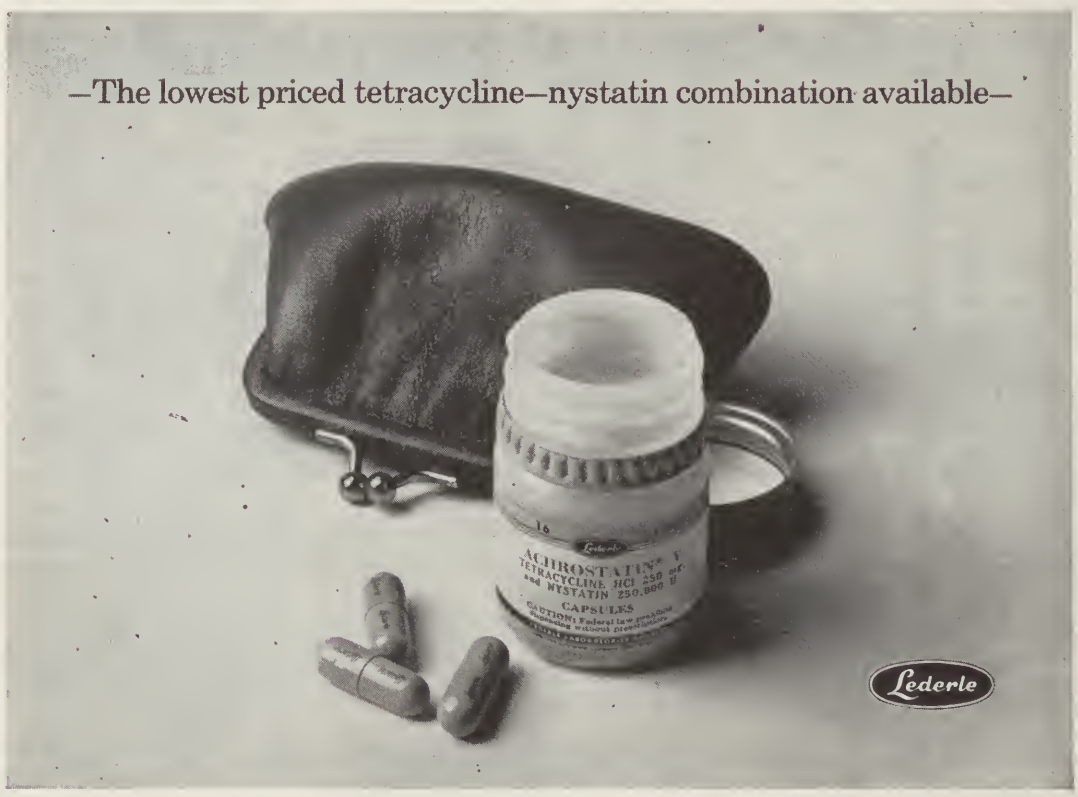
A free medical clinic has been opened on Greenmount Avenue and much concern was expressed by the members of the Board as to the legalities of operating such a clinic and what caliber of medical care was being provided. It was the consensus that the administrator and medical director of the clinic be invited to the next meeting of the Board to discuss the matter.

A National Conference on Medicine and the Federal Coal Mine Health and Safety Act of 1969 will be held in Washington, DC, on May 15-18. The Board agreed that if anyone was attending this conference from the Society, they should be requested to present a report to the Board, but that no official representative should be sent.

The Woman's Auxiliary has suggested that a combined meeting of the Society and the Auxiliary be held during the Annual Meeting in December, but the Board was of the opinion that although the Society would be happy to co-sponsor such a social event, the business of the society could not be adequately appreciated at a primarily social function.

Dr. Classen asked members of the Board to suggest names to him of individuals who might be interested in working towards the formation of a Peer Review Committee for the Baltimore City Medical Society. He stated that he believed that this was a most important function, but that in order to have the committee operate effectively it would need a chairman who was vitally interested in the project.

There being no further business, the meeting was adjourned at 5:45 PM.





JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

A Report to the Fifteen Southern States*

Hospital services for the mentally ill in all Southern states have progressed substantially in recent years. However, statistics published by the Office of Biometrics of the National Institute of Mental Health show that this marked improvement has failed to reduce the appreciable gap in services between the Southern states and the rest of the United States. The net and percent differences in average daily per patient expenditure and ratio of employees to patients is now higher than it has been at any time previously.

AVERAGE DAILY PER PATIENT EXPENDITURE	15 SOUTHERN STATES	REST OF UNITED STATES	NET DIFFERENCE	PERCENT DIFFERENCE
1959	$3.11	$4.66	$1.55	–33.3
1964	4.57	6.77	2.20	–32.5
1968	7.76	11.41	3.65	–32.0
1969	8.81	14.03	5.22	–37.2
NUMBER OF EMPLOYEES FOR EVERY 100 PATIENTS				
1959	26.9	33.9	7.0	–20.5
1964	35.5	41.7	6.2	–14.9
1968	46.1	54.9	8.8	–16.0
1969	48.5	61.6	13.1	–21.3

Total hospital maintenance expenditures by the 15 states more than doubled in this ten-year period (from $136 million in 1959 to $337 million in 1969) and average daily per patient expenditures are now two and one-half times the 1959 figure. However, since comparable changes occurred in the other 35 states, the South's relative position has remained essentially unchanged. In fact, the South's daily average in 1969 of $8.81 was exceeded by all except one of the other 35 states. Arkansas, which had the highest per patient per day cost among Southern states ($16.75), ranked 14th nationwide. Kentucky, with the second highest cost among Southern states ($12.86), ranked 25th nationwide. Maryland ($12.50) ranked third among Southern states and 28th nationwide. Related to this, the average size of the patient population declined 17.5% (from 126,824 to 104,671) in the Southern states during this ten-year span and 16.8% in Maryland (from 8,952 to 7,451) while the comparable figure for the rest of the country was 24.0% (from 415,311 to 273,962).

This disparity does not necessarily reflect a lesser interest and support for mental hospital programs. It does relate to the relatively lower economic level of most Southern states. Figures released by the U.S. Department of Commerce indicate that the South's per capita income continues to be one fourth lower than the rest of the United States with only Maryland being above the national average. This in turn has produced lower than average per capita expenditures for all state services.

The South has been characterized as an area in transition. Gradual economic and social development can be expected to produce in the mental health field a concomitant continuation of the progress experienced in recent years. However, it must be recognized that unless this is rapidly accelerated much of the South will perpetually continue to lag appreciably behind the rest of the United States.

* Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.



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executive director's newsletter

June, 1970

THE FACTS !!

According to the AMA Newsletter, Robert J. Myers, Actuary for the Social Security Administration, presents a comparison of annual increases in physicians' fees and in general wages, in his new book, MEDICARE.

The comparison is instructive, especially in view of the criticism of physicians' fees by those seeking a scapegoat for the high costs of Medicare and Medicaid. The average annual increase in fees for the years 1956 through 1965 was 3.0%, but the average annual increase in wages during the same period was 3.6%.

Increases were 5.9% in 1966; 7.3% in 1967 and 5.5% in 1968, but the total fee increase during the three-year period was only 1.0% above the rise in the general wage level.

NEW PUBLICATION

The new (second) edition of Current Procedural Terminology is now available from the American Medical Association at a cost of $2 per book. A five-digit code is used in this new publication.

NEW COMP SCHEDULE

It is anticipated that the newly revised Workmen's Compensation Fee Schedule will be effective about July 1, 1970. The public hearing held on May 14, at the Workmen's Compensation Commission offices brought little discussion and objection to changes in payment for physicians' services since the last schedule was published, effective November 1, 1961.

It is understood that the schedule will remain under constant scrutiny so as to effectively reflect changes in costs to the physician and the public. Target date for publication of the next schedule is 1972.

AMA LONG RANGE PLANNING

The AMA's Committee on Long Range Planning presented a lengthy report to the AMA House in November, 1969. Action on the recommendations contained in the report was deferred until June, 1970, when the AMA House asked State Medical Societies to prepare and submit resolutions to effect the policy-recommendations contained in the report.

AMA LONG RANGE PLANNING (cont'd)

The Faculty's Council met in special session on May 12 to consider recommendations of the Policy and Planning Committee. Full details can be obtained from the Faculty office.

DRUG ABUSE ACCESS CENTERS

The first of several Drug Abuse Coordinating and Counseling Centers in the state will be opened in Baltimore in the near future. The center will be located at 25th and Calvert Streets and will be manned by employees of the state's Drug Abuse Authority.

The centers will provide the public with access to information on treatment facilities and local assistance.

MORE MEDICAL SCHOLARSHIPS

The Wicomico County Council has established two medical scholarships amounting to $2,000 a year. These amounts are available to persons who agree to practice in the county for a five-year period following graduation from medical school.

While county residence is not required, preference in awarding the scholarships would undoubtedly be given to residents.

SEMIANNUAL SESSION

The Faculty's Semiannual session will again be held in Hershey, Pa., at the Hotel Hershey. The House of Delegates will meet Friday morning, September 11, 1970, at 9:30 a.m. Following the meeting will be a scientific program.

Reservation forms, found elsewhere in the Journal, should be completed and mailed directly to the Hotel.

PHYSICIAN MANPOWER STUDY

The Faculty, in cooperation with the Department of Health and Mental Hygiene, is completing a study of the physician manpower supply in Maryland.

When finished, physician population by county, specialty, school of graduation, postgraduate training and age group will be available. It will be the first comprehensive, detailed study of practicing physicians in the state.

John Sargeant

Executive Director

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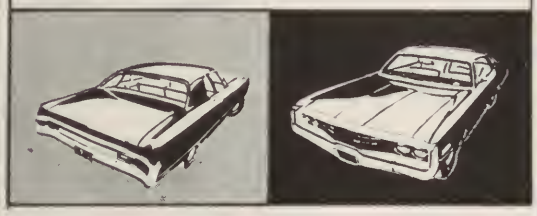
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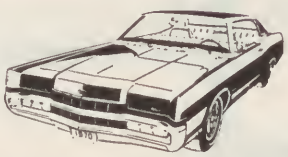
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Library and History Committee
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News

Medical Library Association, 1970

The Medical Library Association meeting, May 17-22, gave medical librarians from the more northerly states a taste of summer and a second chance within the past year to convene for continuing education courses, conferences with other similar group librarians, and a glimpse of a beautiful city. Texas librarians programmed the Medical Society Group luncheon meeting this year, with Dr. Alton Ochsner, President of Alton Ochsner Foundation, speaking on "Medical Libraries and the Practicing Physician".

State-of-the-Arts—Med-Chi Library

A state-of-the-arts summary of the library's activities is being developed, which may question the validity of surveys and statistics such as the recent questionnaire circulated by the Faculty. Several physicians who use the library regularly do not remember answering or even seeing the questionnaire. The Library Committee would appreciate a direct communication regarding the effectiveness of the library's services. Please take a moment to drop us a note!

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

American Academy of Pediatrics. Committee on Infectious Diseases.
Report. 16th ed. Evanston, Ill., 1970.

American Medical Association
Current procedural terminology. Burgess L. Gordon, editor. 2d ed. Chicago, 1970.

American medical directory. 25th- ed.
Chicago, American Medical Association, 1969- .

Apte, Robert
Halfway houses: a new dilemma in institutional care. London, Bell, 1968.

Baltimore (City) Health Department. Medical Care Services.
Physicians' manpower survey. Study undertaken by the Medical Care Services during the summer of 1967, Martin K. Gorten, director. Baltimore, 1968.

Barney, Vermon
Conditioning exercises; exercises to improve body form and function. By Vermon Barney, Cyntha C. Hirst and Clayne Jensen. 2d ed. St. Louis, Mosby, 1969.

Canadian medical directory. 16th- ed.
Toronto, Seccombe House, 1970- .

Control of chemotherapy; a symposium held in the Wright-Fleming Institute, St. Mary's Hospital Medical School, London, March 1969. Edited by P. J. Watt. Edinburgh, Livingston (distributed by Williams & Wilkins, Baltimore) 1970.

Current topics in surgical research, v. 1-
Edited by George D. Zuidema and David B. Skinner. New York, Academic Press, 1969- .

Diehl, Harold Sheely
Tobacco and your health: the smoking controversy. New York, McGraw-Hill, 1969.

Federman, Daniel
Abnormal sexual development; a genetic and endocrine approach to differential diagnosis. Philadelphia, Saunders, 1967.

Gleason, Marion
Clinical toxicology of commercial products; acute poisoning. 3d ed. Baltimore, Williams & Wilkins, 1969.

Goodrich, Charles
Welfare medical care; an experiment, by Charles Goodrich, Margaret Olendzki and George Reader. Cambridge, Mass., Harvard University Press, 1970.

Gordon, Burgess
Clinical cardiopulmonary physiology. Sponsored by the American College of Chest Physicians. (Editors: Burgess Gordon, Richard A. Carleton and L. Penfield Faber) 3d ed. New York, Grune & Stratton, 1969- .

Jablonski, Stanley
Illustrated dictionary of eponymic syndromes and diseases and their synonyms. Philadelphia, Saunders, 1969.

Jacobson, Edmund
Modern treatment of tense patients; including the neurotic and depressed with case illustrations, follow-ups, and EMG measurements. Springfield, Ill., Thomas, 1970.

Johns Hopkins University. John Work Garrett Library.
Medals relating to medicine and allied sciences in the numismatic collection of the Johns Hopkins University; a catalogue by Sarah Elizabeth Freeman. Baltimore, Evergreen House Foundation, 1964.

Kyle, Robert
Medicine and stamps. Edited by R. Kyle and M. Shampo. Chicago, American Medical Association, 1970.

Lichtenstein, Louis
Diseases of bones and joints. St. Louis, Mosby, 1970.

McLennan, Charles
Synopsis of obstetrics. By Charles McLennan with the collaboration of Eugene Sandberg. 8th ed. Saint Louis, Mosby, 1970.

Maryland. State Department of Economic Development.
Directory of science resources for Maryland. 4th- ed. Annapolis, 1970- .

Mecham, Merlin
Development of audiolinguistic skills in children. St. Louis, Green, 1969.

Meszaros, William
Cardiac roentgenology. Plain films and angiocardiographic findings. Springfield, Ill., Thomas, 1969.

Meyers, Frederick
Review of medical pharmacology. By Frederick Meyers, Ernest Jawetz and Alan Goldfien. Los Altos, Calif., Lange Medical Publications, 1968.

Moore, Condict
Synopsis of clinical cancer. 2d ed. Saint Louis, Mosby, 1970.

Neef, Jacoba Catharina de
Clinical endocrine cytology. New York, Hoeber, 1965.

Pathology annual, v. 1-
New York, Appleton-Century-Crofts, 1966- .

Reynolds Historical Library.
Rare books and collections of the Reynolds Historical Library; a bibliography. University, Ala., University of Alabama Press, 1968.

Ryan, Robert
Synopsis of ear, nose, and throat diseases. By Robert Ryan and others. 3d ed. Saint Louis, Mosby, 1970.

Scientific basis of drug dependence; a symposium. Edited by Hannah Steinberg, New York, Grune & Stratton, 1969.

Seminar on Diseases of the Liver, Chicago, 1967.
Proceedings . . . Sept. 27, 1967. Given by Edward A. Gall, Hans Popper and Hugh Edmondson. Moderator: David Dahlin. Edited by Martin Swerdlow. Chicago, 1968. (American Society of Clinical Pathologists. Proceedings of the 33d Seminar).

Straatsma, Bradley
The retina; morphology, function and clinical characteristics. Editors: Bradley Straatsma, Michael Hall, Raymond Allen and Frederick Crescitelli. Berkeley, University of California Press, 1969.

Turnbull, Rupert
Atlas of intestinal stomas. By Rupert Turnbull and Frank Weakley. St. Louis, Mosby, c1967.

Vitamins and hormones; advances in research and applications. v. 26- New York, Academic Press, 1968.

Weinerman, Edwin
Social medicine in Eastern Europe; the organization of health services and the education of medical personnel in Czechoslovakia, Hungary, and Poland by Richard Weinerman, with the assistance of Shirley B. Weinerman. Cambridge, Harvard University Press, 1969.

Wittenborn, J. R.
The response to meprobamate; a predictive analysis. New York, Raven Press, 1970.

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Generation Without Shadow

MATTHEW DEBUSKEY, MD
Associate Professor of Pediatrics
Director, The Johns Hopkins Community Pediatric Program

Highlight of the 21st annual convention of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland held recently in Baltimore was the keynote address by Matthew Debuskey, MD, Associate Professor of Pediatrics at The Johns Hopkins University.

Dr. Debuskey was born in Baltimore, was graduated from The Johns Hopkins University, and received his MD degree from The Johns Hopkins University School of Medicine. He interned at Johns Hopkins Hospital, and served as resident at New York Hospital in New York city, and at Children's Memorial in Chicago. The War Years saw Dr. Debuskey as Major Debuskey in the United States Army. He was certified by the American Board of Pediatrics in 1949. He has the reputation of being "a Doctors' Doctor". Dr. Debuskey is a member of the Baltimore Association of Retarded Children, the Maryland Association of Mental Health, a Director of the Health and Welfare Council, and is the Medical Coordinator of the Head Start Program of the State of Maryland.

Confusion is battering our society today. This is not unprecedented. On many previous occasions our complacency has been shattered, and changes—significant changes—have occurred. But the current agitation, at times approaching panic, is singularly characterized by an eerie and startling feature: A generation has lost its shadow.

This is not a local phenomenon. Signals are sounding throughout the world. The deafening clamor on the streets of our cities is echoing on the lawns of our suburbs, and is reverberating on the fields of our countryside.

This is not solely an American phenomenon, nor is it limited to countries of affluence. Its existence has been publicized in England, France, Japan, Mexico, Mainland China, and students, in time-honored tradition, are providing the spearhead. A parent generation has lost its shadow.

The timid and the fearful, particularly among the elders, recognize in the din a tocsin of alarm, and respond with either abject submission or stern retribution. Cynics and pessimists identify an ominous tolling of disaster that is implacably threatening the existence of our society. Impulsive youth hears joyous peals of release and liberation. To the great majority of us, however, both young and old, the full significance is not clear, and it is the speculative interpretations and fragmented responses that cleave us into factions, and threaten the linkage between our generations of youth and adult, children and parents.

Generally, in the past, social divisions have occurred in a vertical plane, grouping regions of the world, segments of a country or sectional slices of a local population. There has existed separation of patrician and plebe, wealthy and impoverished, conqueror and vanquished. But currently, disrupting our composure, there is occurring a horizontal rift, breaching on the shibboleth of age, challenging seriously our powers of adjustment.

It is the cultural obligation of adults to orient children and youth to the customs and habits of the society in which they live. It enables the senior to complete his life in a recognizable setting that provides the ineffable satisfaction of having lived

This material, in substance, was initially presented at Florence Crittenton Northeast Area Conference.

by standards, which being perpetuated, are automatically transmuted into universal truths. It permits youth to mold himself into a niche that will not be abrasive, however distorted he might become.

The leading generation has always been able to vindicate its judgments and to reinforce its self-esteem, by looking back and down to recognize its own silhouette in the shadowed generation that was to succeed it. But now that image, vanished, challenges the verity of our codes and the substance of our values. Our senechals command the shadow to return, our seers ascribe its obliteration to flood clouds of destruction. But youth, denouncing the rheumy vision of its elders, points upward to the sun at its zenith, casting no shadow, but instead vividly illuminating the flaws and blemishes that mar its generation of predecessors.

Which point of view is more accurate is difficult to say. Probably none is totally true, none is completely wrong. Certainly none is sufficiently practical to be used as the sole guide in the readjustment of goals and directions that seem so essential today.

There are multiple factors operating constantly in the gradual evolution of social change. It is the unprecedented conjunction of these many circumstances that is provoking the estrangement of the two generations. In general, age is more rigid and resists change to the structure with which it is familiar and secure; youth, pliable and undaunted, is inclined to risk change and to stake opportunity against security.

The model of generation imprinting has operated well through the long ages of man, during which time change has been slow and pedestrian. But, almost abruptly on this vast scale of history, we are swept forward with an incontinent speed and an accelerated pace, that makes hazardous any prediction for a decade in the future, and literally defies any prophecy a generation removed.

In the past, there has existed, from time to time, a social issue of parents versus peers, but never to the degree that pertains today. The changing form of our primary social unit, the family, is supportive of this development. The traditional extended family, where control or domination is exercised by the titular family head, is rapidly disappearing. This arrangement, in which a senior member, usually a male "pater familias" was responsible for the conduct and performance of each of the family juniors, often extending for several generations, created clusters of individuals whose clan-like customs and creeds bound, almost inextricably, antecedents and descendents, to a uniform code of behavior and a legacy of common beliefs. This classical model is being replaced by the nuclear family unit—a father, mother, and dependent children—in which setting independence is encouraged and the ideal structure for the transmission of tradition is attenuated.

One basis for this change is increased mobility. Mobility in its various forms and guises, achieved through revolutionary technological advances and critical social changes.

Geographic Mobility

We no longer travel painfully by foot and slowly by sail, but by engines, successively steam, internal combustion, turbine, jet, each swifter and more economical than its predecessor. So swiftly do we fly, that our daily physiological cycles, the circadial rhythms, are disrupted in ordinary transoceanic flights. No longer is one confined throughout life to an occasional visit to the county fair or to a periodic meeting in a neighborhood church or pub. No longer are families clumped like bulbs budding off a parent root, but are swept like pollen far from their site of origin. The children of a family might be scattered from coast to coast, exposed to new conditions, requiring solutions alien to monolithic concepts of earlier generations.

Occupational Mobility

The freedom of vocational selection and an unimpeded opportunity to pursue it, is recognized as a stable plank in the platform of any progressive society. Seldom do we find the butcher's son a butcher, the farmer's son a farmer, or the tradesman's son in trade. We encourage youth to climb the rungs of economic privilege.

Social Mobility

However, slowly, there is developing a disruption of groupings by ethnic or religious identity. Social isolation based on these barriers is a diminishing factor.

Feminine Mobility

Encouraged by the economic needs of several wars, the liberation of woman from her limited traditional roles has proceeded rapidly. Her newly achieved freedoms—political, economic, educational, and, recently, sexual—present a most vivid illustration of the changed viewpoint of successive generations.

Communication Mobility

Communication is no longer limited to word of mouth or to a locally oriented weekly newssheet. No longer must we depend on old standard books of reference or a prejudiced journal for a stock of facts for the honing of opinion. The printed page is now voluminous, and wire, wireless, and instantaneous radio and television carry us from a narrowly circumscribed and limited experience to a global exchange of ideas and developments.

This soaring sweep of technological progress and cultural mobility constantly challenges and at times outstrips our psychologic, sociologic and economic

abilities of adjustment to the inevitable changes. Maybe youth, unencumbered by habits and attitudes established in the pre-electronic age, is more likely than we are to make this adaptation successfully.

We seek to provide our children with greater skills in coping with future uncertainties and changes, and raise the level of educational expectations. Two generations ago only 10% of our people completed high school. Presently there is a diminution of unskilled and semi-skilled jobs to accommodate our untutored or deficiently equipped youth. With the increased premium residing in diplomas, we are insistently urging all youth to complete at least a secondary education. In a few years, 50% of them will be exposed to the intellectual processes of a college experience. We induce them by persuasion, by cajolery, by coercion to increase their formal education and to sharpen their mental abilities. The present generation, if not wiser, is certainly more educated than the previous one. However, when from this laboriously achieved vantage point they focus on us their newly acquired scientific methods and principles of logic, to question our values and directions, we become shocked at their attitudes and incensed at their behavior.

They question our position on the relaxational expedients of contrasting generations: complacency toward alcohol; alarm toward marihuana. Yet both can cause distorted concepts of time and space, both can produce psychological dependence, and both can be responsible for accidents and violence.

They question our confusion in establishing an age for their initiation into the adult community: draft eligible at 18 years with risk of death or mangling, but no privilege to express an opinion by vote until 21, nor even trusted to consume alcoholic beverages until 21; the right to drive at 16, to have sexual intercourse at 16, but not to marry until 18.

And particularly relevant to this colloquium today, they question our attitudes toward sex, the secrecy which shrouds it, and the values that our code expresses.

Before pursuing the opinion of youth on this subject, it might be pertinent to cite several well recognized observations.

- The appearance of sexual maturation in our children is occurring at a younger age. If measured by menarche, the initiation of menstruation, there are statistics in England and America, disclosing during the last century a reduction in onset from an average age of 16, to one of 12; and the level is still declining. Possibly this is related to improved nutrition, better public health and hygiene.
- Levels of economic maturation are reached at a later age. With jobs scarce for youth, and education increasingly prolonged, the achievement of adequate financial means to sustain separation from parental support and the cost of an independent married household has been delayed.
- Our eagerness to accelerate maturational and cultural processes has resulted in a paradox. The watchword of "earlier and swifter" has extended to social experiences, and their progressive advances have carried our young to the ultimate sexual goal before we are ready to condone it.

These are some of the reefs that confront youth and must be recognized by all of us interested in the growth processes of adolescence. They must be marked on any chart designed to guide our young people through the hazardous passage to the deep waters of adult life.

Concerning our sexual tenets the questions that they pose, openly by the more articulate, tacitly by those less bold or less logical, are numerous.

Are we confusing love and marriage? The possession of both is an ideal base for sanctioning a sexual union. But if love without marriage is insufficient basis, then what about marriage without love? Is physical intimacy barred if love departs from marriage? Are divorce codes changing in recognition of the spiritual element in the legal union of man and wife? Are we hung up on the religious or on the secular aspects of the problem?

Is it age that determines our permissiveness, and are we as confused in establishing its limit, as manifestly we are in other aspects of maturity?

Does the old conventional double standard still operate? Is our prohibition more rigid when applied to girls than it is to boys? Is it fear that supports this aspect of our social code? Indeed, until recently the utilization of anxiety has been the major instrument in our sex educational plan. Fear certainly is a powerful force controlling behavior. At best, however, it has a negative inhibiting influence that requires regular reinforcement. Moreover, with the rapid medical and sociologic changes that are occurring and with the advanced knowledge that the juniors are acquiring, it might be useful for us to reexamine the reasoning that we employ and to separate phantom incubi from real threats.

First is the fear of pregnancy. This is probably the most formidable bastion that we have constructed. Certainly, its occurrence would appear to be the ultimate humiliation to parents. To the pregnant girl, the physical risk as well as the social, intellectual and psychological dislocations can be a major calamity. In addition, at least to me, one of the most vicious of all the effects is the malevolent stigma that is attached to the unconsulted child. A belated marriage that so often follows such an event frequently compounds the problem by uniting two people incompatible in the creation of any meaningful marital structure. But with the tremendous developments occurring in the area of planned con-

ception, it will not be long before extremely effective measures of contraception will be available. Then this real fear will become a spectral anxiety and its effect will be lost.

Second is the fear of disease. With newer and more effective drugs becoming increasingly available, this deterrent is rapidly fading. Furthermore, disease never occurs as result of contact between two people—there must be a third to introduce the infection. Promiscuity exists, but as an emotional distortion or a subcultural standard; a revival of the spiritual values of love and solicitude, to displace conquest and debauchery would result in a reduction of this desultory behavior. A segment of adolescents do advocate, at least in principle, the adoption of this behavioral code.

Third is the fear of a blemished reputation, damaging the maintenance of group esteem and the prospect of a felicitous marriage. It is true that group evaluation of conduct is another powerful incentive influencing behavior. But it is peer judgment that is most effective. With an increasing divergence of generational opinions and the increased tendency to peer orientation, the strength of this previously effective restraint will depend on the developing attitudes of youth.

Reiss, in 1959, conducted a survey at five schools, two colleges and two high schools in Virginia and one college in New York.[1] He analyzed and classified 821 responses into five separate categories expressing attitudes toward sexual intercourse.

	Male	Female
1) Abstinence	**28%**	**55%**
2) Permissiveness with affection	**24%**	**15% ***
3) Transitional double standard	**18%**	**10% ***
4) Orthodox double standard	**9%**	**13%**
5) Permissiveness without affection	**13%**	**2%**

*** 25% of the girls selected premarital intercourse with affection.**

Condensed by Smigel & Seiden [2]

Freedman interviewed college girls and reported 22% had experienced premarital intercourse.[3]

An interesting study explored the corelation between permissiveness and marital or family status.[4]

STATUS	Percent endorsing permissiveness	
Single	**44%**	
Married and childless	**23%**	
Married with pre-teen	**22%**	
Married with pre-teens & older	**17%**	
Married with teens & older	**13%**	**(Modified)**

Two interpretations might be proposed. First, there is a probable age difference of 20 or more years between the first and last divisions, and these differences could represent a progressive alteration in attitude developing between generations.

Second, the percentages depict a change of posture dependent on altered life circumstances. I should guess this latter to be the more likely explanation. And I am inclined to suspect that to some degree the very liberal and generous stance of youth today will be more constrained with their children tomorrow.

These then are some of the wedges that intervene between the generations, that threaten to broaden the cleft, and that interrupt continuity and communication.

We are advised constantly, as parents, to maintain avenues of communication with our children. But even when we carefully and consciously avoid the tendency for this dialogue to deteriorate into a didactic lecture or a carping diatribe, the language of feelings comes through clearly and emphatically. If parents find it so difficult to consider variations in such simple issues as dress, hair styles, dance and music, then how can they be expected to preserve any composure in discussing more fundamental differences in position? How can we dismantle the barriers erected between the abstract idealism of youth and our own personalized version of pragmatic realism? How do we avoid the stigma of hypocrisy in denouncing marihuana and indulging alcohol? The establishment of effective reciprocal communication cannot be commenced when children reach the critical age of adolescence. A parent is not a mime in a stock company who can effectively and instantly change his roles of authority, disciplinarian, guardian, etc., to that of confidante or counsellor. The basis for this latter interaction, if ever it can be developed, must be constructed early in life, and at a period when it might conflict with other more timely and appropriate relationships. If a youth recognizes, in the parent-child relationship, a prevailing tone of love and affection, his inclination will be to protect his parents from pain and disappointment, and will result in concealment; if anger and hostility, then exaggeration and retribution; if authority and punishment, then denial; if dependency, then prudence and secrecy. It is understandable, but not logical, for parents to chafe with inadequacy when some other mature and understanding adult, teacher, minister, etc., appears to form a better relationship with their teenaged child than they themselves were able to achieve.

Particularly in the area of sexuality is the senior generation awkwardly immobilized. Operating in this field are not only social habits and values but profound moral and religious implications as well. We have been imprinted so deeply with the notions of sin and secretiveness in sex that the embarrassment

generated in a discussion of many of its vital elements is a deterrent to any useful dialogue.

These are some of the dilemmas that we face in the evaluation of a parent-peer gap. Is it exaggerated? We are regularly bombarded through communications media with activities of the bizarre and of the combative. Obviously these depict a small but sensational segment of youth. Pertinent, however, are the questions: 1) Do they represent the outcropping of a sizeable subsurface deposit? 2) Does the extreme *deed* of the uninhibited few indicate the *creed* of the restrained many? Is it minimized? or does there exist a normally standard interval that is essential for progress? If it is of a threatening nature, either personally or socially, what do we do to reestablish some degree of serenity and stability?

Can we examine our own established attitudes and values, and attempt to redefine our position on the basis of intelligence and reason rather than prejudice and passion? Possibly if we relent a bit our stiff-necked posture and lean somewhat, the reappearance of the shadow, however foreshortened, will be reassuring.

One issue that we shall have to reappraise is our reaction to the attitude of youth to sex and sexuality. Sometimes I wonder if "war is too important to trust to generals" whether or not sex is too vital an aspect to life to trust to embarrassed and often unknowledgeable parents who can unwittingly transmit their own physical misconceptions and emotional distortions sequentially from one generation to the next. Even the best of marital and sexual adjustments achieved by husband and wife does not automatically endow them with the knowledge or skill to teach the elements of this accomplishment to their offspring. By a structured and formal inclusion in the school curriculum, it is time to recognize sexuality as a behavior pattern extending beyond reproduction and elevated above the sensual or carnal aspects with which it is so commonly equated. The spiritual elements of love and sacrifice and self-respect will have to be integrated into any concept of sexuality that is to serve as an ethical code to the fear-released generations to come.

If honest reassessment of our positions justifies a stand, then we should have the courage to remain firm in that position, impervious to pleas, resolute against intimidation, and staunch against sophistry and intellectualization. Finally, we must, at some time in a child's career, recognize that our active and principal task is ended. We have done our best, hopefully, to launch him into the uncertainty of tomorrow. We have offered him the charts we possess, the designs we have created. How he arranges the ballast to compensate for unsuspected contingencies is up to him. He must be given a chance to learn the strengths and weakness of his own craft. He is the ultimate helmsman. In spite of our accumulation of experience and our eagerness to impart this to our children, it is, unfortunately, a repeated observation, that the same trials and dismal errors seem to be destined for repetition in each generation. But maybe it is high-noon, the accepted moment for mariners to "shoot the sun" and to mark a point on their path toward a destination. Possibly youth, with his advanced knowledge and techniques, might possess a sextant far more accurate in establishing our position, than we can do with our worn systems of dead-reckoning and the triangulation of shadows.

REFERENCES

1. Reiss, Ira S., The Social Context of Premarital Sexual Permissiveness, New York: Holt, Rinehart, and Winston, 1967.
2. Smigel, Erwin O. and Seiden, Rita, The Decline and Fall of the Double Standard, *The Annals, Amer Acad Pol and Soc Sci* 376:6-17, March 1968, pp. 6-17.
3. Freedman, Mervin B., "The Sexual Behavior of American College Women: An Empirical Study and a Historical Study," *Merrill-Palmer Quarterly* 11:No. 1 (1965).
4. Reiss, *op. cit.*



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Advantages of Quantitative Cultures in Diagnosing and Treating Acute Bacterial Pneumonia

Quantitative culturing of homogenized sputum led to more frequent isolation of pathogens than did routine qualitative culturing. It also provided pertinent information on superinfection and the effectiveness of antimicrobial chemotherapy.

Identification of the specific pathogen in acute bacterial pneumonia is necessary for rational and appropriate therapy. Routine qualitative bacteriologic cultures of sputum may lead to erroneous diagnosis and inappropriate therapy, particularly in patients with chronic obstructive lung disease.

Because tracheobronchial secretions are bacteriologically sterile, sputum cultures should show growth of only an etiologically significant organism. Rarely are such clear-cut results obtained. Even a carefully produced deep sputum from the bronchi becomes contaminated in passing through the bacteria-laden pharynx.

An organism which can cause inflammation of the lungs should be present in sputum in greater numbers than the contaminating pharyngeal residents. However, pneumonia pathogens, particularly *D. pneumoniae* and *H. influenzae* are irregularly distributed in sputum. This leads to inaccurate results when the portions of sputum which contain few or no pathogenic organisms are inoculated onto media. Liquefaction and thorough mixing of sputum permit more uniform sampling.

The present study of 20 pneumonia patients admitted consecutively into two hospitals at different periods was designed to evaluate the usefulness of quantitative cultures of fresh homogenized sputum in the diagnosis of bacterial pneumonia and in following its clinical course. Medical histories, physical examinations, and pulmonary-function tests revealed that the 19 men and 1 woman in this study had chronic obstructive lung disease. None had received antimicrobial treatment before admission.

PREPARATION OF CULTURES

All sputum specimens collected on admission and at intervals during illness were liquefied, homogenized, and buffered before being streaked onto a culture medium of blood, chocolate eosin-methylene blue, and Sabourand dextrose agar. Estimates of culturable aerobic microorganisms were obtained after 24-hour incubation at 37°C. Routine cultures from 18 were also studied by the usual clinical laboratory techniques.

The quantitative technique led to the isolation of pathogens in all 20 patients whereas the conventional qualitative technique led to isolation of pathogens in only 7 out of 18.

The initial quantitative cultures prepared from sputum taken on admission uncovered predominant colonies (minimum of 10^7 per ml of sputum) of *D. pneumoniae* in seven patients, *H. influenzae* in eight, predominance of both of these pathogens in three, and *Staphylococcus aureus* in two. They also uncovered colonies of other microorganisms in

J. Kin Pirtle, MD; Patrick W. Monroe, MD; Tim K. Smalley, MD; John A. Mohr, MD; and Everett R. Rhoades, MD. *American Review of Respiratory Disease*, December, 1969 (Vol. 100).

fewer numbers, including *S. viridans,* Candida, and Neisseria.

Quantitative culturing uncovered "superinfection" from gram-negative organisms in seven patients. In the present study, superinfection was arbitrarily designated as the presence of 10^5 per ml or higher concentrations of microorganisms other than *S. viridans* and Neisseria. In these mixed infections there were actually three times as many superinfecting organisms as all other organisms combined.

PATHOGENS OR CONTAMINANTS?

Other investigators have noted that mechanical homogenization without mucolysis increases the sensitivity of sputum cultures. As has already been noted, quantitative culturing uncovered pathogens in all 20 patients.

A number of factors appear responsible:

In the present study, smaller colony counts of common pharyngeal flora, which more uniform sampling permits, provided a reliable guide for differentiating lower-tract pathogens from contaminating pharyngeal flora.

Actually, the sample plated by routine methods constitutes a very small portion of a sputum specimen. Identification of the predominant organisms is necessarily limited to the microorganisms therein. This problem of adequate sampling may be the most important source of error in routine cultures.

Homogenization overcomes the problem in providing culture samples of different portions of a single specimen. Other workers have shown that *D. pneumoniae, H. influenzae,* and *S. aureus* are not always isolated more frequently from purulent than from mucoid portions of sputum.

Previous studies reveal that a much greater yield of *H. influenzae* is obtained from saline-washed sputum than unwashed specimens from the same patients. Apparently, inhibitory factors are removed or destroyed by the washing procedure. In the quantitation procedures, saline diluting solutions appear to have a similar effect.

One study revealed that a combination of *N. catarrhalis* and mucin inhibited *H. influenzae* growth in unwashed sputum, while the liquefying agent, N-acetylcysteine, promoted its recovery. In addition, relatively slow growing *D. pneumoniae* and *H. influenzae* in diluted sputum are not as easily masked by faster growing organisms, such as gram-negative bacilli.

Quantitative sputum analysis provides information as to whether new organisms appearing in the sputum are responsible for true superinfection. When colony counts are low (10^5 or less), use of more toxic antimicrobial agents is usually less urgent than when this information is not available. If the colony count is high, clinical evidence of superinfection will develop in 30% to 50% of these patients. Quantitative analysis also reveals pertinent information concerning the efficacy of antibacterial therapy and a better understanding of the cooperative, competitive, and antagonistic interactivities of bacteria.

The high incidence of *H. influenzae* and *D. pneumoniae* in sputum from pneumonia patients in this study may have been related to the high incidence of underlying lung disease. These are the two most common pathogens associated with exacerbations of bronchial infection in patients with chronic lung disease. Colonization of at least one of them was found on admission in all but two patients who were also found to have chronic lung disease, suggesting that chronic lung disease is common in patients admitted with pneumonia.

There appeared to be significant correlation between elevated bacterial colony counts and the presence of clinical disease. Quantitation culture procedure was found to be rapid and simple and yielded consistent results. Further studies of larger numbers of patients are needed to define more precisely the concentrations of organisms in the sputum that may be significant in various circumstances.

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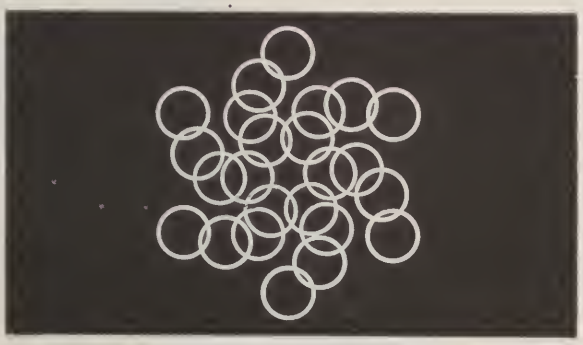
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

The Johns Hopkins Hospital Alcoholism Unit: Half-Way House and In-Hospital Treatment

SHARI MAYER
Editor
Under The Dome
The Johns Hopkins Medical Institutions
Baltimore

Traditionally, alcoholics have been regarded as nuisances by the public, the courts, and the medical profession. As it becomes clearer that alcoholism is a disease—a complex behavioral problem with extensive medical and social consequences—moral attitudes are being replaced by treatment-oriented attitudes.

Beginning January 1969, The Johns Hopkins Hospital began to form a two-phased alcoholism program sponsored by the Office of Health Care Programs. The program is under the direction of Dr. Torrey Brown, associate director of health care programs for East Baltimore, and Dr. Anthony Reading, administrator for the psychiatric liaison service.

The in-hospital phase for alcoholics who also have acute medical problems provides "on-the-spot" alcoholism counselors in the emergency department and on call through the hospital.

First Half-Way House

The other segment of the program is an alcoholism recovery unit (Flynn Christian Fellowship House) located on Gay Street, which is sponsored by a grant from the Maryland State Department of Mental Hygiene.

Although hospitals throughout the state have alcoholism counselors available to patients, The Johns Hopkins Hospital is the first in Maryland to incorporate a half-way house in its treatment of alcoholics.

Since Flynn opened, 31 male alcoholics have been treated there with only two patients needing readmission, according to Ellen Siegel, nurse coordinator for the two programs. Many more have received counseling or have been admitted to the hospital.

Key Is Self-Motivation

"Through the counseling, such as initial counseling, individual counseling, and group therapy, the men become personally motivated to stop drinking," she said. "That's the key—no one can decide for the alcoholic. He must decide for himself to stop."

Miss Siegel is assisted by Nancy Lowe, who is the chief alcoholism counselor for the hospital program, and by James Smith, chief counselor at Flynn House. In turn, there are four full-time counselors at Flynn House and two trainees from the Baltimore City Alcoholism Center at the hospital. The trainees, working under Mrs. Lowe, rotate through the hospital program every two months.

Alcoholics are usually brought to the emergency department by the Baltimore City Police Department. Under a new law, alcoholics are no longer sent to jail. They must be treated at the nearest hospital emergency room, and, according to Dr. Reading, the neighborhood around the hospital has one of the highest alcoholism rates in the country.

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Once inside, the patient is able to see a counselor without being admitted or registering. Here, he is told of the hospital's program and of other agencies which can help him.

Once the alcoholic decides to join the program, he registers and is seen by the medical resident in the emergency department. All candidates for Flynn House must have a physical examination and are treated at the House.

Counseling Helps

If a patient also has an acute medical problem, he is admitted as an inpatient. In addition to regular medical care, he is visited daily by a counselor. Through these daily sessions, the alcoholic learns about vocational rehabilitation and about the variety of social services available to him through the hospital's department of social work.

Upon discharge, most patients choose to spend a week at Flynn House and return to the hospital as outpatients for further counseling and psychiatric evaluation.

An Alcoholics Anonymous group also meets weekly in a room located in the Woman's Clinic.

Since Flynn House serves only male alcoholics, women with similar problems are admitted to the hospital, when necessary, and are then referred to other half-way houses in the city which are designed for them.

As in any new service program there are problems, according to Dr. Reading. The people presently available are able to deal with only a fraction of the needs of the alcoholic patients who use the hospital. But it is a beginning, and gradual expansion is planned, particularly regarding the hospital's community medicine and community psychiatric activities in East Baltimore.

People seeking further information about the program should contact either Mrs. Lowe or Miss Siegel, ext. 3800, or the Office of Health Care Programs, ext. 6553.

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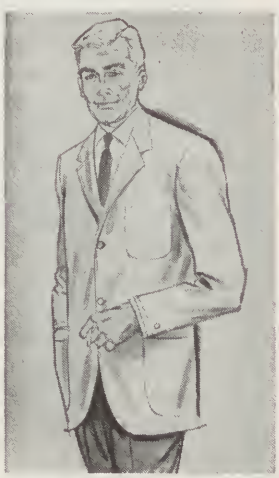
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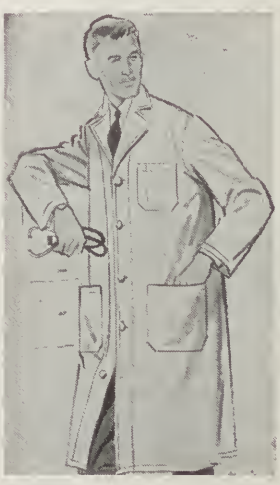
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References: (1) Solerna, L. J.; Ortiz, G., ond Turkel, V.: Vaginitis: A Diognostic and Therapeutic Approach, Scientific Exhibit, presented ot the 115th Annuol A.M.A. Convention, Chicogo, Illinois, June 1966. (2) Nugent, F. B., ond Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Pressure Sores—Their Cause, Prevention, and Treatment

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Injury to the spinal cord is a catastrophic event often made more difficult for the patient to endure because of preventable complications. Among these, with a high rate of incidence, are pressure sores which not only prolong hospitalization but may subtract substantially from the individual's eventual rehabilitation. Such sores inevitably impose an additional burden of frustration and despair upon the patient, add to the cost of his care and, at times, initiate a series of events that ultimately leads to death. It is a sad commentary upon contemporary management of spinal cord injured patients that so few escape this complication. The fact that some do escape is substantial evidence that observance of a few basic rules by both patient and those caring for him should prevent the vast majority of skin breakdowns.

Cause

As Griffith [1] has pointed out, "decubitus ulcer" is really a misnomer since "decubitus" means "lying down". Many ulcers do result from the patient lying in one position too long. However, others arise from sitting, and some even result from prolonged standing on tilt boards or electric circle beds. As long ago as 1853, Brown-Sequard [2] recognized that pressure is the prime factor causing this complication. It follows then that a more precise and meaningful term is "pressure sore" since prolonged pressure is the basic cause. Inasmuch as the spinal cord injured patient has little or no local discomfort from prolonged pressure applied to tissue between a hard, unyielding surface and underlying bony structures, he is particularly vulnerable to this type of injury.

The sites most frequently involved are those with bony prominences immediately underlying the skin. Depending upon the lying position, the sites commonly affected are the skin over the sacrum, greater trochanters, anterior iliac spines, patellae, malleoli, shins, heels, and rib cage, as well as the spinous processes of the vertebrae. In the sitting position, the ischial tuberosities and, in the standing position, the heels and soles of the feet are vulnerable areas. Pressure sores may occur entirely independent of position such as those produced by pressure from plaster casts.

Prolonged pressure unrelieved by change of position leads to tissue anoxia and capillary thrombosis. Cells deprived of essential oxygen and nutrients die. The resulting necrosis may be superficial and involve a relatively small area in thickness; at the other extreme, all tissues down to underlying bone may lose their viability. Often the surface appearance gives little indication of the ultimate size of the sore, but early evidence of serious damage is heralded by two signs—skin redness which does not blanch on pressure, and the formation of a vesicle. The former sign is due to capillary thrombosis following endothelial injury and the latter is due to extravasated tissue fluid, since normal fluid and electrolyte equilibria are destroyed as soon as cell death occurs. Ulceration of the vesicle follows and this, in turn, opens the way to infection. With tissue anoxia con-

tinuing, infection tends to spread widely and rapidly to involve muscles, tendons, fasciae, and eventually bone, unless drainage is free and the causative pressure is relieved. Cultures of this purulent drainage show a wide variety of gram negative and gram positive organisms including staphylococci, streptococci, E. coli, P. vulgaris, klebsiella, and pseudomonas aeruginosa and, on occasion, clostridium perfringens.

Although pressure is the primary cause of tissue breakdown, a number of conditions play important contributory roles. Among these are malnutrition, anemia, incontinence of bowel and bladder which leads to skin maceration and bacterial contamination, mental apathy, and lack of voluntary movement. These contributory factors have been used as a basis for the clinical scoring of patients and serve as a means of identifying those most apt to develop pressure sores.[3]

Although this scoring system was originally introduced as a predictive aid on a geriatric service, we have found its application to spinal cord injured patients a helpful device in drawing attention of personnel to the importance of alleviating threatening contributory factors. The high score of 15 represents maximum potential for developing a pressure sore, a score of 0 minimum potential.

CLINICAL SCORE

A. General Condition	B. Mental State	C. Activity	D. Mobility in Bed	E. Incontinence
0 Good	0 Alert	0 Ambulant	0 Full	0 No
1 Fair	1 Confused	1 Walks with help	1 Slightly limited	1 Occasional
2 Poor	2 Apathetic	2 Chairfast	2 Very limited	2 Usually of urine
3 Bad	3 Stuporous	3 In bed all day	3 Immobile	3 Doubly incontinent

The advantages of such a "predictability scoring system" are:

1. It is simple to use and easily understood.
2. A score of "7" or more indicates extra care must be taken or skin breakdown is likely.
3. Rescoring at regular intervals may indicate a need for an increased degree of vigilance or even a change in nursing management, as a patient's clinical condition improves or worsens.

Second in importance only to prolonged pressure as a cause of tissue breakdown is the application of a shearing force which will disrupt the continuity of tissues and lead to necrosis. This type of injury occurs when pulling a patient across a bed instead of lifting him, or sliding him in transferring him from bed to wheelchair so that the skin and subcutaneous tissues are pulled taut and overstretched. At first the damage may appear slight—an abraded, raw surface with an underlying ecchymotic area—but experience has shown that even with meticulous care, deep ulceration may ensue since tissue injury has already occurred. In contrast to prolonged pressure where time is a measurable factor, shearing forces produce their damage more or less instantaneously because it is the immediate disruptive effect of the shearing force itself on tissue that causes the harm.

Prevention

There are many ways to avoid or mitigate the effects of prolonged pressure. The simplest and most effective, but by no means always the easiest, is a change in position. Even during sleep, we normally move many times; observers report major limb or body movements about every 20 minutes. For the spinal cord injured patient who cannot move himself there are available a number of devices that either move him or effectively reduce the pressure on tissue in vulnerable areas. For many years **orthopedic turning frames** such as the Stryker and Foster Frames have been used; properly padded with pillows and turned at two-hour intervals, skin breakdown can be avoided. **Alternating pressure mattresses** have helped patients who could not be turned, but with these we have experienced some skin breakdown, especially in thin individuals with bony prominences and meager subcutaneous tissue. In recent years the **electric circle bed** has become available. By merely pressing a button, the patient secured to the bed frame is mechanically rotated through a 180° arc, thereby being taken from a supine to a prone position, or back again. Other protective devices have included **lambskins or shearlings,**[4] both natural and synthetic. These are available in various sizes (eight square feet or more) or as smaller pads for use on the heels or elbows.

Theoretically, the **water mattress** would appear to be an excellent solution to the problem of preventing pressure sores, since fluid displacement results in a degree of weightlessness. It has been reported[5, 6] that pressures up to 70 mm Hg or more may be

exerted upon skin overlying the sacrum or greater trochanters with the patient lying supine or on his side. The minimum pressure keeping capillaries open is approximately 25 mm Hg and, at this level, is due primarily to osmotic forces acting through the capillary wall and surrounding tissues. This pressure will be maintained, even though the heart may not be beating, so long as the tissues are viable. The usual intracapillary pressure of course is higher than this, being approximately 40 mm Hg. Thus, it follows that pressures acting from the outside above this level produce ischemia. By "floating" a patient in a water mattress, less pressure is exerted upon the dependent parts of the body with the result that pressures of 50 to 70 mm Hg have been observed to be replaced by pressures of 15 to 20 mm Hg or slightly higher. We have had no experience with the water mattress so we cannot report on its practical value in actual use.

Various **flotation pads** are also available. The Stryker Flotation Pad is a dry gel which simulates body fat in consistency, provides for even distribution of weight, and minimizes the effects of shearing forces that might occur. The Bio-Float Pad employs a foam type of filling encased in a waterproof cover to which a considerable quantity of water is added. This has proven useful for wheelchair seat use over a cut-out seat board, as well as for bed use. The Stryker pad also can be used in both bed and wheelchair.

Self-adherent polyurethane foam dressings have proven especially valuable. Available as Reston self-adhering foam pads from the Medical Products Division of the 3M Company, they are supplied in boxes of ten pads of polyether urethane foam measuring 8½″ x 11″ x ½″. One side of the pad is coated with an adhesive backing which is chemically inert and nonallergenic. According to Line [7] "When adhered to normal, intact skin and kept dry, the foam pad can remain indefinitely without injury to the skin. Reston has been kept in place, secured further by Micropore surgical tape, for as long as eight weeks. If the Reston becomes damp and remains so, maceration and ulceration of the skin can occur quickly. However, when the material is exposed to the air to facilitate quick drying, maceration under the Reston will not take place. Therefore, it is an important nursing measure to maintain the dryness and thus the effectiveness of the Reston."

To summarize briefly, prevention of pressure sores requires:

1. Turning the patient every two hours, thereby relieving pressure over bony prominences;
2. Prophylactic padding of pressure areas;
3. Keeping the skin clean and dry;
4. Correcting nutritional deficiencies, particularly of protein and iron:
5. Maintaining constant vigilance for effects of pressure on the skin of paralyzed or comatose patients;
6. Avoiding wrinkles in bed linen upon which the patient lies;
7. **Never** sliding a patient, since the shearing effect may be as harmful as prolonged pressure.

It has been our practice that any patient showing redness of the skin that does not fade promptly should be grounded until the reddened area is restored to normal color. Light massage to such reddened areas several times a day, plus scrupulous attention to details of skin cleanliness, as well as protection from further pressure on the area, may well spell the difference between a few days in bed or several months healing a resultant ulcer.

On repeated occasions, we have been impressed by the difficulty of preventing pressure sores when bony prominences underlie skin with little intervening subcutaneous tissue. The ischial tuberosities, the sacrum, and even the greater trochanter of the femur vary considerably anatomically and, in many patients with spinal cord injuries, it is a foregone conclusion that these variations may cause trouble. As a consequence we have suggested, and on occasion patients have accepted, prophylactic radical ischiectomies, coccygectomies, and removal of sacral prominences. This is an area of preventive care that we believe has great potential in terms of improving patient morale, shortening hospital stay, and reducing medical expense.

Treatment

Since many spinal cord injured patients reach us with one or more areas of tissue necrosis already an established fact, we are prepared to treat them as follows. The paraplegic or quadraplegic patient is placed on an orthopedic turning frame and a two-hour turning schedule started. The necrotic tissue is surgically debrided as soon as possible, cultures taken, and an enzymatic debriding agent applied. We prefer a sterile ointment containing 10% papain, 10% urea, and 0.5% chlorophyll in a solution of a borate buffer with a pH of 6.2 (*Panafil*).[8] This ointment is applied generously; thick dressings are placed over the area and held in place with elastic bandage and changed daily. This ointment is also available without chlorophyll (*Panafil-White*). Other enzymatic agents such as fibrinolysin and desoxyribonuclease (*Elase*), streptokinase-streptodornase (*Varidase*), and trypsin (*Tryptar*) are available but, being of animal origin, are much more expensive and their use in our hospital has been limited to small or shallow ulcers. Daily cleansing with hydrogen peroxide irrigation followed by sterile saline irrigation and *Panafil* is continued until the ulcerated area is clean—usually within 7 to 14 days.

Following debridement, antibiotic preparations are used depending on the result of sensitivity tests from the cultures taken at the time of admission. Usually, Polymyxin B-Bacitracin-Neomycin (*Neosporin* ointment or powder), or genta-micin ointment will be one of the agents indicated by the laboratory results and all have proven valuable. It has been our practice to continue with one agent for 10 to 14 days and change to another in order to avoid the development of resistant strains. For ulcers that are indolent with slow healing, packing the ulcer with granulated sugar or urea crystals has at times stimulated healing. It is well not to use sugar so long as to dehydrate the tissues. A week to ten days of sugar, then a change to urea crystals for a similar period, and then iodoform gauze packing for ten days is an effective cycle which may be repeated as often as needed. On occasion we have used ultraviolet light but our enthusiasm for this modality is not as great as that of some of its proponents, although on occasion, we have seen apparent benefit from its use. For ulcers involving the ankle or foot, whirlpool hydrotherapy not only helps clean the ulcerated area, but also stimulates healing.

To speed epithelization of a clean but large ulcer, and with the surface showing a pH of about 7.4, split thickness skin grafts may be applied. Another technique, using thin strips of sterile plastic tape placed across the ulcer and held in place by a previous application of tincture of benzoin compound to the skin surrounding the ulcer provides a bridge-like structure along which epithelium may grow.

Once healing is accomplished, the area may continue to present problems of recurring breakdown, scarring, retraction, and adhesion to underlying bone. Excision of the scarred area with replacement by a full thickness skin graft has been a satisfactory answer in many instances. Before proceeding with surgery, our policy has been to allow the ulcer to heal completely. This minimizes the chance of infection with loss of the graft and the disappointment that this entails to all concerned. At the time of operation, bony prominences are excised in an effort to produce a smooth weight-bearing area without protuberance. In the case of ischial tuberosities, the ischia are resected generously and primary closure effected. Many of these patients have large bursae which must be completely removed if future trouble is to be avoided. Large defects over the sacrum can be covered by full thickness grafts swung medially and, if necessary, resultant defects over nonweight-bearing areas can be epithelized with split thickness grafts. In the case of scar tissue adhering to the greater trochanter, removal of the greater trochanter is indicated along with excision of the adherent scar tissue followed by primary closure.

Postoperative care is extremely important. Patients with full thickness grafts over the sacrum and lower back and buttocks are kept face-down on an orthopedic turning frame from four to six weeks with only occasional turning face-up after three weeks. Suction at time of operation to remove blood from under the graft, or later, if a hematoma should form, is important. If the graft has a wide enough base and an adequate blood supply, the suture line should not be disrupted and healing should proceed uneventfully even though a hematoma does develop and needs evacuation. The area must be kept clean and free from fecal contamination; the sutures are removed after two to three weeks. Patients are turned face-up for one hour at meal times, great care being taken not to disturb the graft and avoiding any shearing force being exerted upon it. We have seen one patient following discharge from the hospital who developed new pressure sores involving adjacent areas but the previously grafted site remained intact.

Conclusion

Although reparative procedures are available and results oftentimes most gratifying, **prevention** of pressure sores must play a prominent role in any program that hopes to rehabilitate the quadraplegic and paraplegic patient in the shortest possible time with the least emotional trauma and at minimal expense. Here especially is it true that "an ounce of prevention is worth a pound of cure".

REFERENCES

1. Griffith, H.: *Spinal Cord Injuries*, Chapter 16, edited by Daniel Ruge, MD, Charles C. Thomas, 1969.
2. Brown-Sequard, E.: Experimental Researches Applied to Physiology and Pathology. New York, H. Bailliere, 1853.
3. Bliss, M. R.; McLaren, R.; and Exton-Smith, A. N.: Preventing Pressure Sores in Hospital: Controlled Trial of a Large-celled Ripple Mattress, *Brit Med J* 1:5537, 394, February 18, 1967.
4. Wool Product Development Report No. 8, Shearings for Hospital Patients, May 1966.
5. Weinstein, J., and Davidson, B.: A Fluid-support Mattress and Seat for the Prevention and Treatment of Decubitus Ulcers, *Lancet* 2:625-626, September 25, 1965.
6. Harris, Charles: Flotation as an Aid in the Treatment of Decubitus Ulcers, *J Amer Geriatrics Soc* 15:7, 605-610, July 1967.
7. Line, R. E.: Polyether Urethane Foam—A Nursing Tool in the Prevention and Treatment of Decubitus Ulcers, *Nurs Clin N Amer* 1:3, 417, September 1966.
8. Miller, J. M., et al: Clinical Experience with Panafil, *Postgrad Med* 22:6, 609-613, December 1957.

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Hans R. Wilhelmsen, MD, has performed many plastic repair operations on our patients and to him we owe a large debt of gratitude for what he has taught us in the surgical prevention and treatment of pressure sores.



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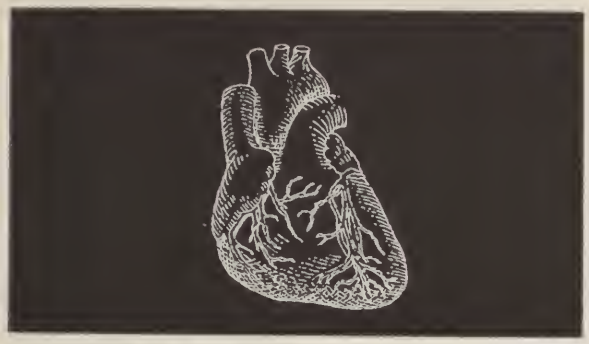
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the heart page

Heart Disease in Pregnancy

LUIS F. GONZALEZ, MD
Baltimore

Heart disease in pregnancy is best understood by considering the potential difficulties associated with a variety of congenital and acquired heart lesions superimposed on the physiologic changes that accompany pregnancy.

Dr. John Quincy Adams, among others, has pointed out that a peak in cardiac work-load occurs in the 28th to 30th week of pregnancy, at which time it is approximately 30% above the nonpregnant level. For reasons which are far from clear, the cardiac work-load, which is determined for the most part by the cardiac output, returns rapidly to the nonpregnant level around the 36th week, where it remains until delivery. Immediately after delivery there is another abrupt increase in cardiac output of approximately the same magnitude as the first peak, and a return to normal over the next two weeks. Ueland and co-workers indicated recently that changes in cardiovascular dynamics at labor and delivery cannot be satisfactorily explained, but a common factor appears to be a redistribution of blood volumes.

The normal physiology of pregnancy can be distorted in the cardiac patient in various ways, but a common denominator in several of these cases is congestive heart failure. Congestive heart failure is the most serious complication of pregnancy in cardiacs, and the most frequent cause of death. It is most frequent in cardiacs who become pregnant after age 35, and worsens sharply after the fifth month of pregnancy, with progressive worsening in the eighth and ninth month. It rarely manifests itself for the first time during labor except in congenital heart disease. In Goremberg's Series, one notes that in 77 cases of congestive heart failure, 80% developed before the last month of pregnancy. Schenker has pointed out that at Hadassah Hospital congestive heart failure in the first trimester of pregnancy is considered a reason for therapeutic abortion.

The diagnosis of heart disease in pregnancy can be related to heart disease diagnosed prior to the pregnancy, or to signs and symptoms of heart disease first noted subsequent to the pregnancy. Signs and symptoms usually increase in magnitude as the pregnancy progresses. The meaning of these signs and symptoms and of their increase in magnitude must be reevaluated repeatedly. Murmurs are a most controversial point. Hockstein at Cornell University has recently reviewed this problem. He points out that the first and second heart sounds are normally accentuated because of the hyperkinetic state and tachycardia. At times the accentuated first sound may be confused with mitral stenosis. An increase in the intensity of the pulmonic sound is associated with an increased force and rate of closure of the pulmonic valve. A third heart sound in early diastole is often associated with increased blood flow from the atria to the ventricles.

Innocent pulmonic systolic murmurs are associated with increased blood flow across the pulmonic valve, and may be associated with hypervolemia and increase in cardiac output. These murmurs must be distinguished from aortic stenosis and its variants, from interatrial septal defect, from pulmonic stenosis, and from anomalous drainage of the pulmonary veins.

Innocent supraclavicular arterial murmurs are usually heard on the right side, and over the carotid vessels. They can be confused with murmurs of aortic or pulmonic stenosis. They disappear when the patient moves her shoulders posteriorly while one listens at the supraclavicular fossae.

Innocent diastolic murmurs are usually maximal over the pulmonic area, occur early in diastole, are blowing in quality, and are of short duration like the Graham Steell murmur. They are believed to be

associated with dilatation of the main pulmonary artery. It has been pointed out in a study at St. Luke's Hospital in St. Louis, Missouri, that 18% of prima gravidas free from detectable heart disease develop such early diastolic murmurs.

Venous hums are usually continuous murmurs with diastolic accentuation, are maximum in the lower anterior neck in the supraclavicular area and are associated with increased blood flow in the internal jugular veins.

Mammary souffles are usually noted during the last two trimesters, and usually disappear after the completion of the pregnancy. At times they first appear in the postpartum period, and during lactation are associated with engorged mammary veins. Because they may be systolic in timing or have a continuous blowing quality they must be distinguished from patent ductus arteriosus and A/V fistula.

Heart disease in pregnancy can be related to previous rheumatic lesions, congenital heart defects, thromboembolic phenomena, vascular catastrophes, myocardial infarctions, and myocardiopathies. As noted at the beginning of this discussion, the common denominator in these disorders is usually congestive heart failure.

The subject of arrhythmias has been reviewed by Mendelson, and of special interest is heart block. Congenital heart blocks were considered benign because of the lack of associated myocardial or valvular damage in contradistinction to acquired heart block. If asymptomatic the patient should be left alone, but if necessary a pacemaker may be used during delivery.

Knapp and Arditti at Cornell University pointed out that the incidence of heart disease in pregnancy decreased from 3.2% in 4,366 pregnancies evaluated in 1953, to 1.6% in 5,080 pregnancies evaluated in 1965. This decrease was explained almost entirely by a decline in the cases of rheumatic heart disease. In 1953, 88% of heart disease noted in these patients was rheumatic in origin, whereas in 1965 only 5% was rheumatic. The number of cardiac patients requiring therapeutic abortion declined from 12 in the period 1953 through 1959 to two patients in the period from 1962 to 1965. From 1953 through 1959, 23 patients with rheumatic heart disease underwent a mitral valvotomy during pregnancy, as compared to three in the period from 1962 through 1965.

From the Cornell data, the following have been considered indications for surgery: those patients in the first and second trimester with predominant mitral stenosis and progressive cardiac disability; those patients with mitral stenosis refractory to medical treatment; and Class III and IV patients with mitral stenosis who become pregnant. Probably the most ideal time for performing cardiac surgery is between the 18th and 24th week of pregnancy.

Interruption of a pregnancy in a patient Class III or IV prior to six months gestation may be justified particularly if the patient is unable or unwilling to remain at bed rest during pregnancy. Pudendal block or local perineal infiltration is considered satisfactory and safe; spinal and saddle block are best avoided because of the danger of decreasing blood pressure.

In some medical centers the indications for mitral valvotomy are the same as those for the nonpregnant cardiac. At Hadassah University, these indications are progressive heart failure which does not respond to conservative therapy while the patient is hospitalized, mitral stenosis with recent thromboembolism, and pure mitral stenosis.

Acute cor pulmonale in pregnancy has been extensively reviewed by Mendelson. Cor pulmonale refers to right ventricular enlargement with or without heart failure, secondary to intrinsic conditions of the lungs or pulmonary circulation, or both. The first signs of cor pulmonale may include a complaint of tightness of the chest, onset of or increase in the accentuation of the pulmonic valve closure sound, dyspnea, cyanosis, venous engorgement, and rales at the lung bases. Therapy includes rapid intravenous digitalization, oxygen inhalation, tourniquet phlebotomy and aminophylline. Acute cor pulmonale may develop following intraluminal embolic pulmonary vascular obstruction due to thrombus, air, fat, fibrin, or amniotic fluid.

In thromboembolism, serious circulatory disturbances develop only after obliteration of more than one half of the cross sectional area of the pulmonary vessel. Cardiac output then decreases if myocardial ischemia occurs. Electrocardiographic abnormalities may include right axis deviation, right bundle branch block, ischemic ST-T changes, prominent Q waves in lead 3, and inversion of T waves in leads V2 and V3. X-ray of the chest may show a characteristic triangular or truncated shadow. The incidence of pulmonary embolization in pregnancy is increased in sickle-cell anemia, sickle-cell hemoglobin C disease, polycythemia, heart block, atrial fibrillation, and bacterial endocarditis.

The cardiac manifestations of the toxemias of pregnancy have been described in detail by Dr. J. Swarthwout at Emory. Basically, in preeclampsia there is an increase in the peripheral vascular resistance; the heart must work harder to pump the same amount of blood per unit of time; the pump reaches its mechanical limits and fails. Prevention of heart failure includes reduction of the peripheral vascular resistance (via vasodilators, termination of pregnancy, reduction of blood volume, correction of anemia, prevention of rapid intravenous infusion of fluids, etc.) reduction in muscular efforts and prevention and treatment of arrhythmias and respiratory problems.

Myocardiopathy, although incompletely understood, is a most interesting type of heart disease in

pregnancy. Numerous descriptive names have been applied to include "idiopathic, myocardial degeneration associated with pregnancy and especially the puerperium" (Bellet); "toxic post partal heart disease", (Hull); "idiopathic myocardial failure in the last trimester of pregnancy and the puerperium", (Meadows); and many others. It should be understood however that there is no agreement as to whether or not there is such an entity as "myocardiopathy of pregnancy".

Friedberg suggests classifying as post partal heart disease only those cases which have had no previous history of heart disease or heart failure, before, during, or soon after delivery. Gilchrist describes two different groups of cardiomyopathies in pregnancy and puerperium. One group presents with congestive heart failure; the other with angina and tachycardia. Whereas in the first group the patients are symptom-free within years, in the angina tachycardia group the patients have protracted symptoms.

In a review of the obstetrical histories of 15 patients with cardiomyopathies, Brown and co-workers doubted that a cardiomyopathy of pregnancy really existed as a separate entity, although they considered the possibility of one case in their series as possibly representing a myocardiopathy of pregnancy. A group of nine cases of heart failure occurring for the first time in the last trimester of pregnancy or in the puerperium was evaluated by Nagaratiam and co-workers in Ceylon. The data suggested to the authors that heart disease in the last trimester of pregnancy is a distinct clinical entity, ie, a cardiomyopathy of pregnancy. Five of the nine patients were young women (20 to 30 years), seven were multiparous, five of whom had seven or more pregnancies. Their symptoms began from eight days before to eight weeks after delivery, and three patients developed a transient elevation of the diastolic blood pressure in excess of 100mm/Hg. The ECGs revealed nonspecific T wave inversion in eight of the nine patients. The age group in this specific series is in contrast with that of Crisp and coworkers who had emphasized an older maternal age. This type of heart disease in pregnancy is one which obviously needs further evaluation in order to establish it as a specific entity associated with pregnancy.

There are numerous types of heart disease which pose potential complications to pregnancy. Also, numerous murmurs of little or no significance can be readily misinterpreted in a pregnant woman. In view of these facts and the recent advances in surgical techniques and the ready availability of modern surgical procedures, it is important to all who evaluate pregnant women to consider the points raised herein.

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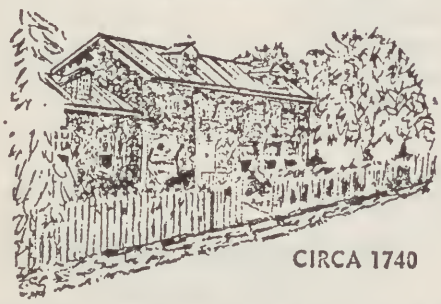
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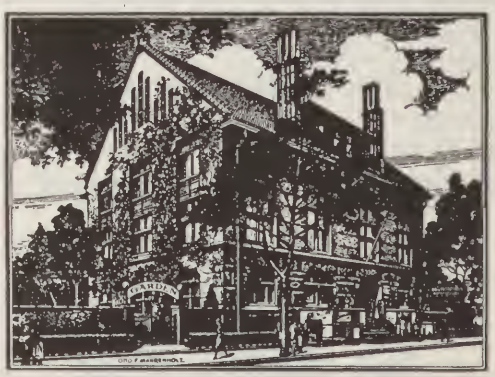
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Rubella Campaign Report for Baltimore City

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The city-wide Rubella Immunization Program was sponsored jointly by the city and state medical societies in cooperation with the public and parochial schools, the State Department of Health, the National Foundation—March of Dimes and volunteers. Members of the City Health Department Rubella Committee include John B. Saratsiotis, MD, Chairman; John B. De Hoff, MD, Deputy Commissioner; James D. Carr, MD, Assistant Commissioner of Local Health Services; Allan S. Moodie, MD, Director, Bureau of Communicable Diseases; Miss Alice Sundberg, Director, Bureau of Public Health Nursing; Mr. Johnny Westerholm, U.S. Public Health Service Immunization Project Coordinator; and Mr. Joseph Gordon, Director, Bureau of Health Information; and Robert E. Farber, MD, Commissioner of Health.

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Baltimore Nurses Exchange 24
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Breon Laboratories 41
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Deutsches Haus Restaurant 140
Dinner Bell Inn & Motel 23
Diplomat Motor Hotel 22
Dow Chemical Co. 135
Edgewood Nursing & Convalescent Home .....Cover 2
Eleven East Chase Street Corporation 8
Esplanade Apartments 124
Flint Laboratories 14-15
Franklin Uniform Co. 128
Karl M. Graf & Co. 12
Harrison Hall 23
Highland Hospital 104
Hilton Nursing Home .....Cover 3
House in the Pines Nursing Homes 122
Hynson, Westcott & Dunning, Inc. 1
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Roche Laboratories .....Cover 4
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Sakura Palace 140
Schering Laboratories 17-20
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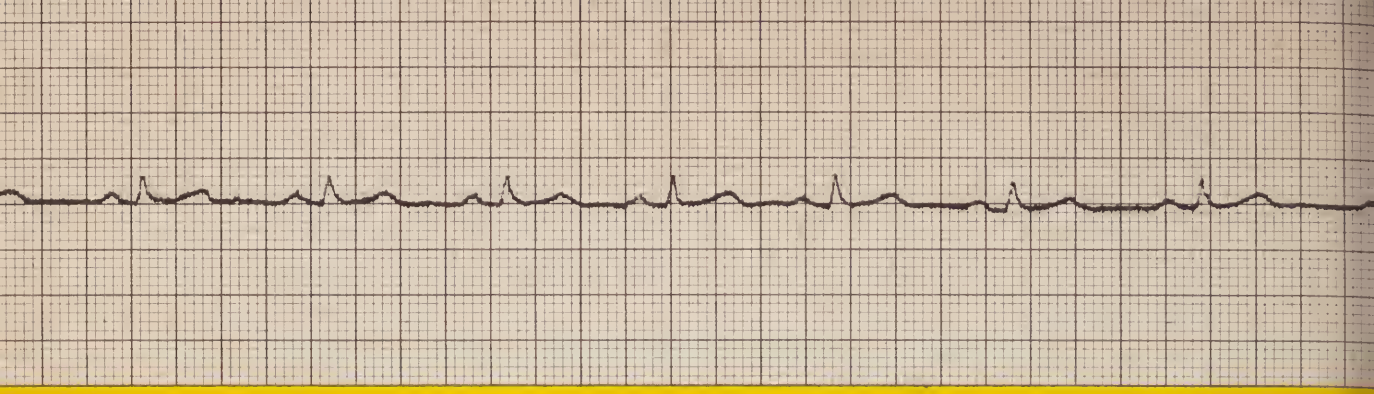
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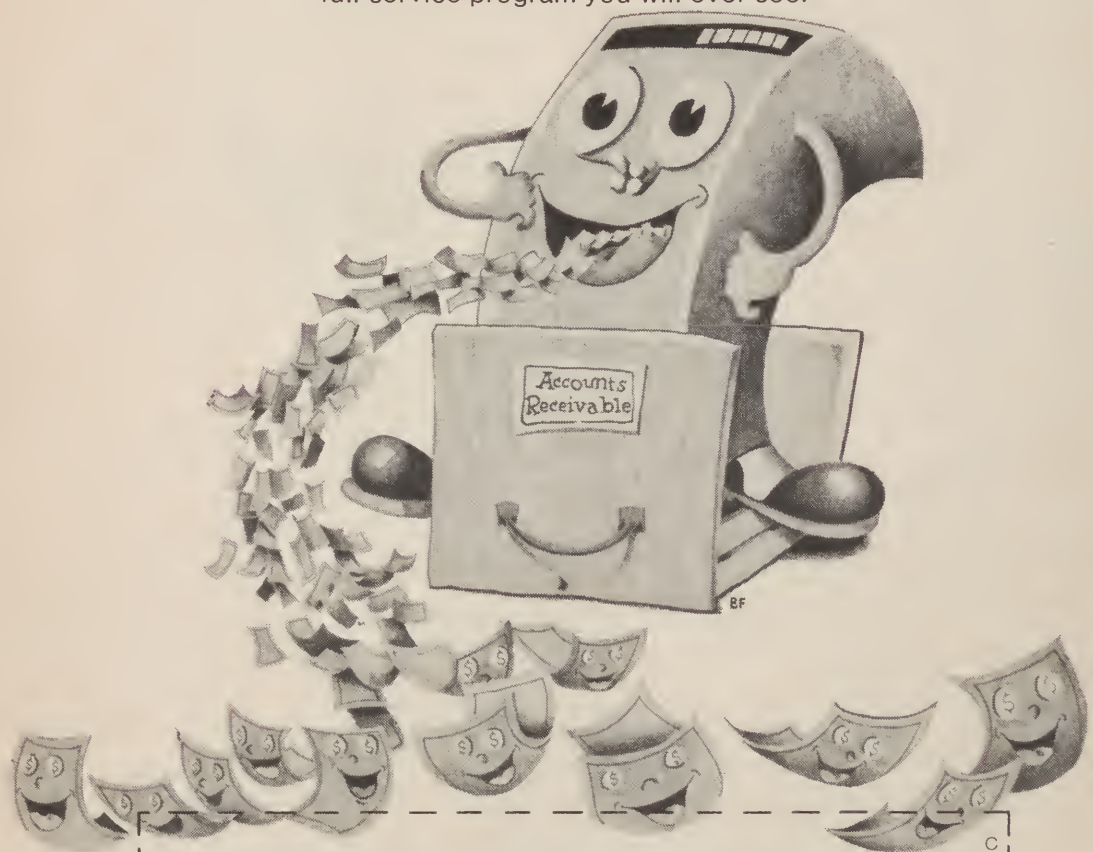
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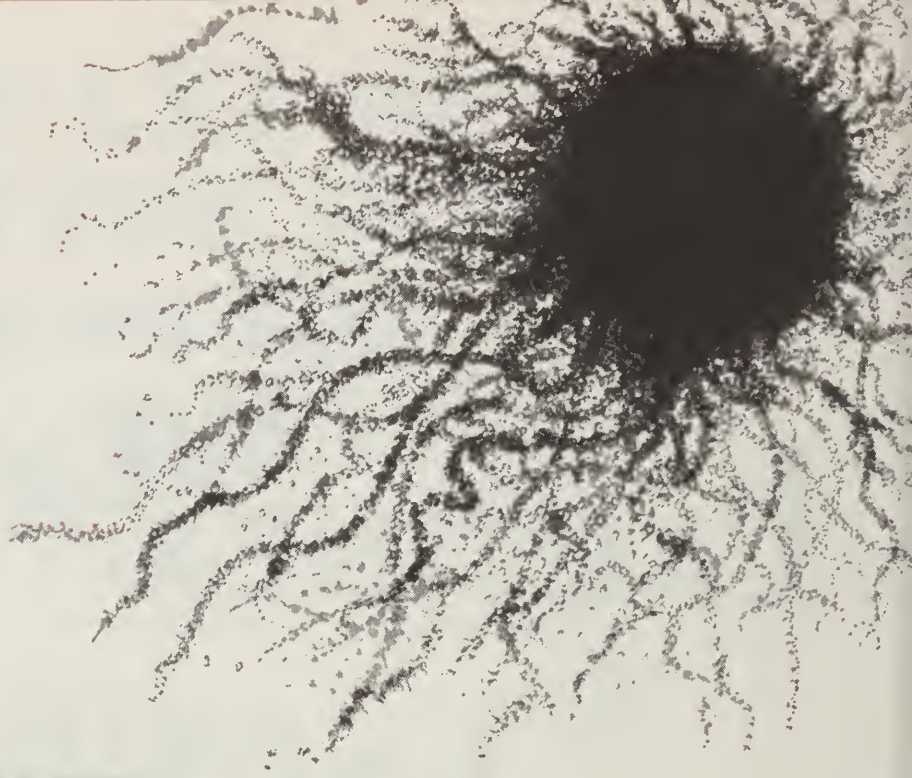
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CONTENTS:

State of the State's Health, Neil Solomon, MD, PhD; Matthew Tayback, ScD 48

"The recently formed State Department of Health and Mental Hygiene was established in compliance with legislation passed by the 1969 session of Maryland's General Assembly and signed into law by Governor Mandel. On July 1, 1969, the department was activated. The new department has concentrated its efforts in five major areas, all designed to better serve the health needs of people throughout the state."

Disaccharide Intolerance: A Review for Practicing Physicians, Arthur E. Cocco, MD; Gualberto C. Gokim, Jr., MD; Barbara Jane Carbary, RN 51

"It was felt that a review of the present concept of sugar intolerance would be of value to the practicing physician in his daily contact with patients.

"It is the purpose of this paper, therefore, to review disaccharide intolerance with clinical pathophysiologic clarification and dietary management."

Murine Typhus: Recent United States Surveillance and Report of an Unusual Case, Harold Mellin, MD; John B. MacGibbon, MD; Lawrence P. Levitt, MD; John H. Janney, MD 56

"The reported incidence of murine typhus (typhus fever) in the United States has been declining almost steadily for the past 15 years. The following case, which is the only one reported from Maryland in 1968, is presented as a reminder that murine typhus still occurs in the United States and may pose a difficult diagnostic problem, particularly when rash is not present."

The Role of Computers in Electroencephalographic Analysis, Antonio Stazio, MD 59

"Over the past two decades, during which the computer has become an increasingly popular tool in scientific research, much work has been undertaken in the general field of computer assisted diagnosis. To this end, however, the complexities of the problem have not permitted any great advances: A breakthrough, in fact, has occurred only in one specific area—electrocardiography (EKG).

Treatment of a Highway Accident Victim, Stuart V. Grandis, MD ... 62

A case history presented during a session of Medical Grand Rounds at the Faculty's Annual Meeting in 1969.

Acute Renal Failure, Glenn D. Lubash, MD 63

"This presentation will review the natural history of acute renal failure and illustrate therapeutic principles as they pertain to the presented case."

DEPARTMENTS:

Maryland State Department of Mental Hygiene—Admission Rates at Record Level in All Age Groups 13

Heart Page—Beta-Adrenergic Receptor Blockade in the Treatment of Cardiac Arrhythmias, Bertram Pitt, MD 30

Your Medical Faculty at Work, John Sargeant 66

Maryland State Department of Health 73

Tuberculosis—Metabolic Changes Associated with the Cessation of Cigarette Smoking 75

Baltimore City Health Department—Nutritional Status of Baltimore City School Children and School Food Program, John B. Saratsiotis, MD, MPH, and Joseph Gordon 85

Rehabilitation Notes—Renal Involvement in Spinal Cord Injuries, Douglas G. Carroll, MD 87

Library Page—New Pride in an Osler Gift, Lee Ash 91

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ON THE COVER: A reminder of the hot and sizzling summer months, the fun and excitement of the fourth of July, and the spirit of independence with which this country was founded.

Rubeola Notice 5

Semiannual Meeting Hotel Reservation Form 7

Executive Director's Newsletter 9

Woman's Auxiliary 19

Mediation Committee 27

Medical News 35

The Month in Washington 38

Semiannual Meeting Program 96

Certified Medical Representatives Institute Research Study 99

Advertising Index 101

Classified Advertising 102

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Doctors take note...

RUBEOLA ALERT

From January 1 until June 4, 1970, 1,245 cases of measles (rubeola) were reported to the State Health Department, as compared with 33 at the same time in 1969. During this period there were three deaths and several cases of encephalitis which could be attributed to measles. Almost all cases occurred in unimmunized children.

According to information obtained through the Maryland Infant Immunization Surveillance Program, approximately 70% of infants in the state have received rubeola vaccine by the age of two. However, in 15 of the 24 subdivisions of the state, the number of children who have received the vaccine is lower than this state average. In addition, even in those subdivisions where levels are above the state average, there are pockets of susceptible children large enough to sustain small outbreaks.

Measles vaccine (rubeola) should be given routinely at 12 months of age to all well children. The killed rubeola vaccine is no longer recommended nor commercially available. A single injection of the further attenuated measles vaccine or one injection of the attenuated measles vaccine with measles immune globulin at this age is sufficient, according to current information, to confer lifetime immunity.

JULY 15- , 1970
MARYLAND GENERAL HOSPITAL/UNIVERSITY OF MARYLAND HOSPITAL

Internal Medicine Board Review Course: Maryland General Hospital, 827 Linden Avenue, Baltimore. This course is designed to prepare physicians for the ABIM written exam in October, but is open to all physicians interested in internal medicine. Registration: free to house officers and fellows of any accredited hospital; $15 for practicing physicians. Contact: Paul G. Pretsch, Director of Public Relations, Maryland General Hospital, 827 Linden Ave., Baltimore, Md. 21201.

JULY 15-17, 1970
AMERICAN HEART ASSOCIATION

3 Days of Cardiology—Clinical Decisions in Cardiology: LeChateau Champlain, Montreal, Quebec, Canada. Contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Md. 21201.

JULY 24-25, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Annual John Tomlin Memorial Cancer Lectures—Gynecologic Malignancies: Medford, Oregon. Topics will include uterine malignancy, ovarian neoplasia, vulvar pathology, practical methods, gynecologic malignancies, diagnosis, treatment, complications. Contact: Frank A. Moore, MD, Chairman, 777 Murphy Road, Medford, Oregon 97501.

JULY 26-31, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

16th Annual Southern Obstetric and Gynecologic Seminar: Asheville, North Carolina. Contact: George T. Schneider, MD, Program Chairman and Secretary, 1514 Jefferson Highway, New Orleans, La. 70121.

AUGUST 7, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Course—Applied Gynecologic Pathology: New Hyde Park, New York. Contact: Long Island Jewish Hospital, 270-05 76th Avenue, New Hyde Park, New York 11043.

AUGUST 9-12, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Advanced Seminars in Obstetrics and Gynecology: Lake Arrowhead, California. Contact: UCLA School of Medicine, UCLA Center for the Health Sciences, Los Angeles, Calif. 90024.

AUGUST 16-21, 1970
AMERICAN ACADEMY OF PHYSICAL MEDICINE & REHABILITATION/AMERICAN CONGRESS OF REHABILITATION MEDICINE

Combined 1970 Meetings: New York Hilton Hotel, New York, New York. The meetings will include scientific sessions, seminars, symposia, round-table discussions, graduate education programs, and technical and scientific exhibits. For program and registration information, write either organization at 30 North Michigan Avenue, Chicago, Illinois 60602.

AUGUST 18-21, 1970
AMERICAN MEDICAL ASSOCIATION

2nd World Meeting on Medical Law: Statler-Hilton Hotel, Washington, D.C. Topics to be discussed will include drugs, health care, psychiatry and the law, transplantation, medical and legal education, and medical secrecy. Contact: General Secretariat, Apotheekstraat 5, B-9000 Ghent, Belgium.

AUGUST 20-22, 1970
DIVISION OF CLINICAL ONCOLOGY, UNIVERSITY OF WISCONSIN

9th National Conference on Therapies for Advanced Cancers: University of Wisconsin Postgraduate Center, Madison, Wisconsin. Chairman: Fred J. Ansfield, MD, Professor of Clinical Oncology. For additional information, write: R. J. Samp, MD, Program Coordinator, University Hospitals, Madison, Wisc. 53706.

AUGUST 23-28, 1970
INTERNATIONAL DIABETES FEDERATION

Seventh Congress: Buenos Aires, Argentina. The program will consist of symposia, lectures, and conferences. Write: VII Congreso, Federacion Internacional De Diabetes, Dr. V. G. Foglia, Paraguay 2155-7° Buenos Aires, Argentina.

SEPTEMBER 6-12, 1970
AMERICAN HEART ASSOCIATION

6th World Congress of Cardiology: London, England. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

SEPTEMBER 8-11, 1970
FEDERATION OF FRENCH SPEAKING SOCIETIES OF GYNECOLOGY AND OBSTETRICS

23rd Congress: Brussels, Belgium. Write: Prof. R. Vokaer, Secretaire General du Congres, Service de gynecologie et obstetrique, Hopital Brugmann 4, Place van Gehuchten, Bruxelles 2, Belgique.

SEPTEMBER 14-16, 1970
AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY

Course—Current Practice of Clinical Electroencephalography: Washington, D.C. The course is designed to review the principal applications of the EEG to clinical medical practice. Write: Donald W. Klass, MD, EEG Course Director, Mayo Clinic, Rochester, Minn. 55901.



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executive director's newsletter

July, 1970

RESOLUTIONS DEADLINE

Deadline for receipt of resolutions to be considered at the Semiannual Meeting in Hershey, Pa., on Friday, September 11, 1970, is

FRIDAY, JULY 17, 1970

All resolutions must be in the Faculty office by that date.

Room reservations for Hershey, Pa., should be sent directly to the Hotel Hershey. Deposits are required on all hotel reservations.

TRIENNIAL LICENSE REGISTRATION

Triennial Reregistration of licenses to practice medicine has been modified during the past two years. Those whose names begin with the letters indicated will receive their reregistration application in the years shown:

A-G 1969 H-N 1970 O-Z 1971

Physicians whose license registration has expired need not be concerned until the fall of the year indicated. Reregistration forms will be mailed prior to the registration dates.

CODES OF COOPERATION

The medical profession has developed Codes of Cooperation with other professions that spell out ethical (and sometimes legal) considerations involved in working with other professions.

An increasing numer of complaints are being filed with the Faculty by physicians against attorneys who have failed to protect the physician's fees or charges from settlements or awards granted to patients for reports and testimony.

Physicians are urged to make themselves familiar with the Medicolegal Code of Cooperation; as well as the other Codes of Cooperation. Copies of these may be obtained at the Faculty office.

An attorney may properly advance fees for medical reports, testimony, etc., in anticipation of awards to their clients. The physician must, however, look to the patient for payment of his fees for medical services.

CODES OF COOPERATION (cont'd)

In all cases, the attorney is expected to protect the physician's charges wherever possible. There is no legal requirement to do so, but most lawyers see that outstanding bills are paid to physicians from settlement funds.

Physicians may not look for payment for their medical services on a contingent basis.

RUBEOLA ALERT

Rubeola (7-day measles) has dramatically increased the first five months of 1970 with three deaths. (See elsewhere in this Journal for further information.)

PUBLICATIONS BEING PREPARED

Being prepared for the printers are the following three publications which will be available early in the fall of 1970:

1. Laws, Rules and Regulations with which Physicians Must comply.

   The updating of this publication will contain latest information, including legislation adopted at the 1970 General Assembly. In addition, it has been expanded to include the various Codes of Cooperation as well as Ethical Standards adopted by the Faculty's Council or House of Delegates.

2. A compendium of policy decisions that have been reached by the Faculty's Council and Mediation Committee over the years. This outlines ethical policies of the Faculty, and positions that should be helpful to physicians in their everyday practice.

3. 1970 Handbook (now available).

Copies of the first two publications will be mailed to all members when they are available. Additional copies may be obtained in the Faculty office.

REVISED MEDICAL PRACTICE ACT

The Revised Medical Practice Act has been signed into law by the Governor and went into effect on July 1, 1970.

While there are no substantive changes in the law, the statute elucidates certain areas which were confusing.

John Sargeant
Executive Director

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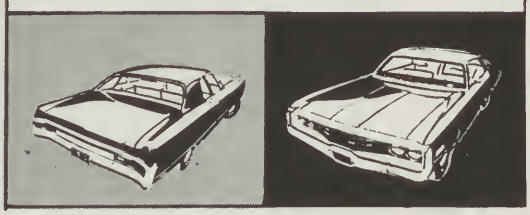
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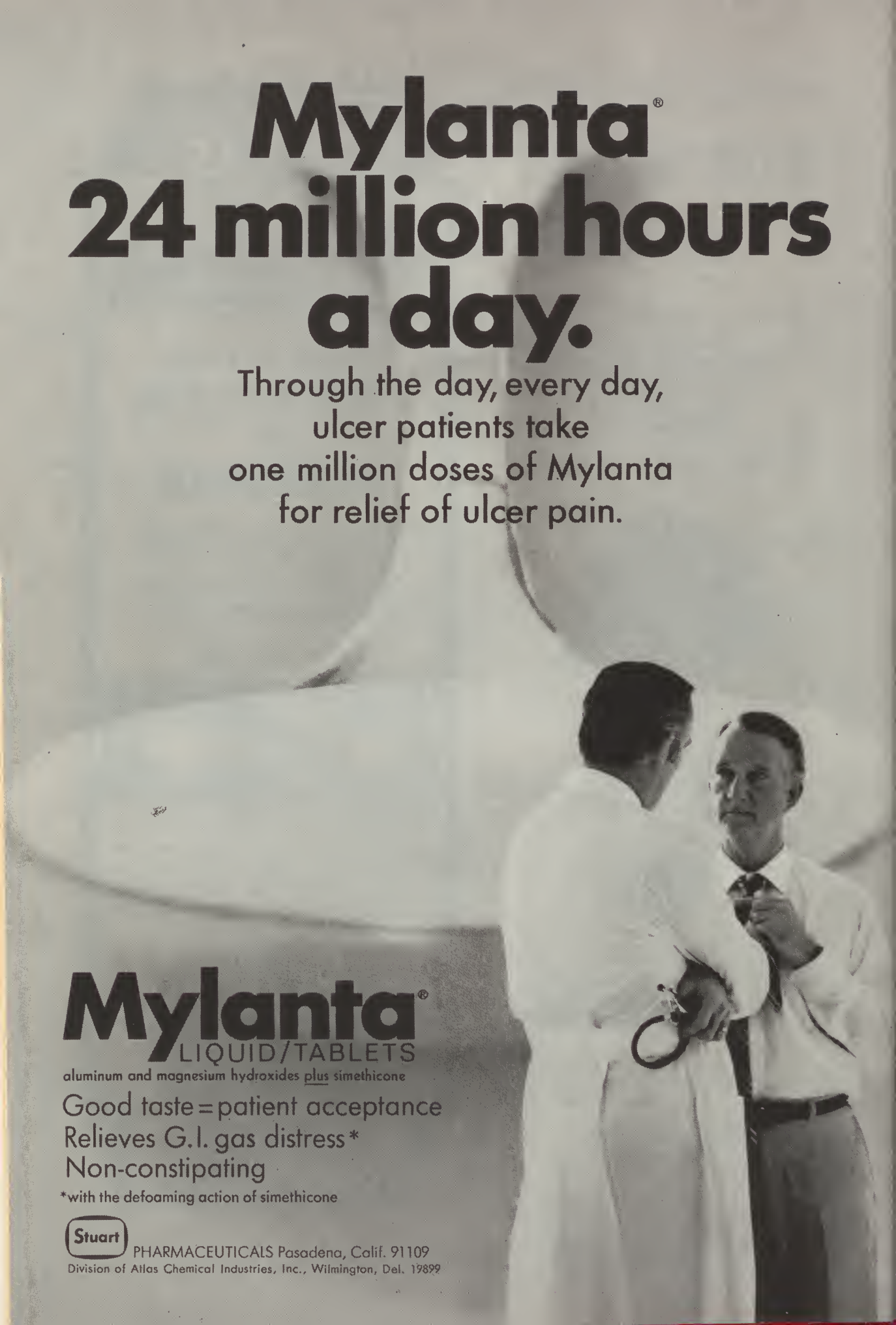
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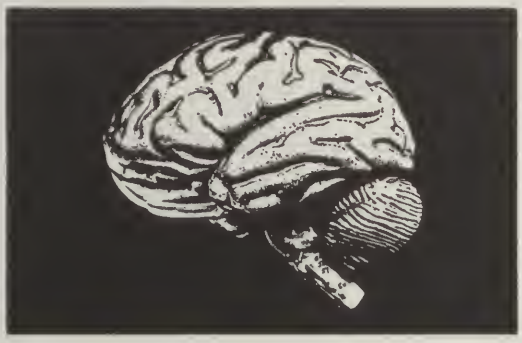


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Maryland State department of mental hygiene

Admission Rates at Record Level in All Age Groups

Admission rates for all age groups to Maryland's state-operated mental hospitals increased between 1962 and 1968. That is, proportionally, admissions increased much faster than the general population. As shown in the following table, rates increased half or more in all age categories under 65, and rose at a somewhat lower percentage in the two upper age groups. During this six-year period the total admission rate increased 59.8% (from 224.4 to 358.7 per 100,000 Maryland residents 5 years of age or older). A further rise in this rate to 416.6 occurred in 1969, and it is expected to reach 430 in the current year.

AGE—SPECIFIC ADMISSION RATES*—FISCAL YEAR

AGE GROUP	1968	1966	1964	1962	PERCENTAGE CHANGE (1968 vs. 1962)
TOTAL-NUMBER	11,997	9,673	7,871	6,221	+92.8
RATE	358.7	306.6	265.6	224.4	+59.8
5-14	23.5	28.3	17.5	15.8	+48.7
15-24	281.9	230.0	193.4	166.1	+69.7
25-44	538.4	468.1	403.7	343.5	+56.7
45-64	546.2	439.2	359.5	297.8	+83.4
65-84	340.0	348.2	364.9	325.8	+4.4
85 AND OVER	846.6	771.2	612.8	694.2	+22.0
MEDIAN AGE	41.7	41.3	41.5	41.4	+0.3

** Number of admissions per 100,000 estimated Maryland residents in specified age group.*

Most other states have reported comparable data. Primarily, this upward movement reflects a growing number of admissions for short-term intensive treatment of acute nonpsychotic disturbances together with an increase in the number of patients requiring multiple hospitalizations. Schizophrenia and other psychotic disorders accounted for 33.5% of the 6,221 admissions in 1962, and 17.4% of the 11,997 admitted in 1968. During this period, admissions for disorders related to old age decreased from 11.7% to 5.4% while admissions for acute conditions, such as alcoholism, other personality disorders, and psychoneurotic reactions rose from 40.5% to 62.1%. In 1962, 43.9% of all admissions reported a previous psychiatric hospitalization. By 1968, this had increased to 58.2%. During the first nine months of the current year the rate was 60.9%.

Since half of all new admissions are now released within less than two months, and virtually all within one year, the number of resident patients has been reduced appreciably despite the rising number of admissions. In 1962, there was an average of 8,291 hospitalized patients; this decreased to 7,711 in 1968, and dropped further to 7,451 in 1969. Our estimate for 1970 is 7,150.

Mental hospitals are in a state of transition, with a gradual shift from a chronic long-term custodial population receiving minimal care to an acutely ill patient group requiring maximum, high-level professional services. Average daily expenditures per patient can, therefore, be expected to continue rising at the current rate of increase. This trend will be further accelerated with the Department's current development and expansion of coordinated community-centered services and programs.

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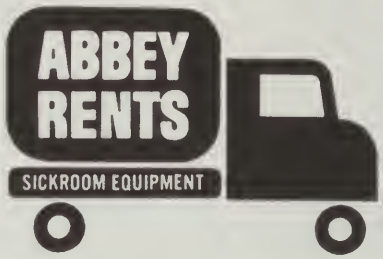
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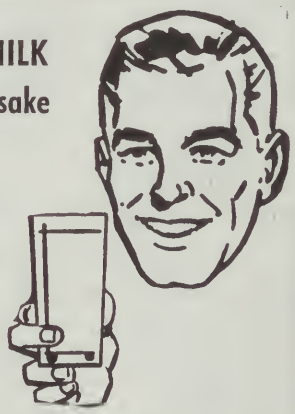
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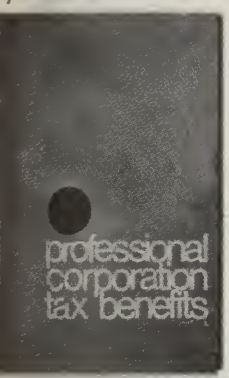
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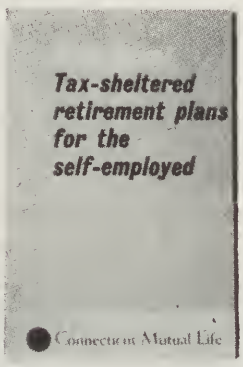


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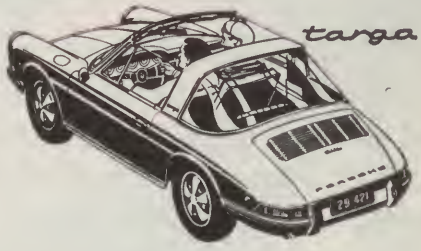
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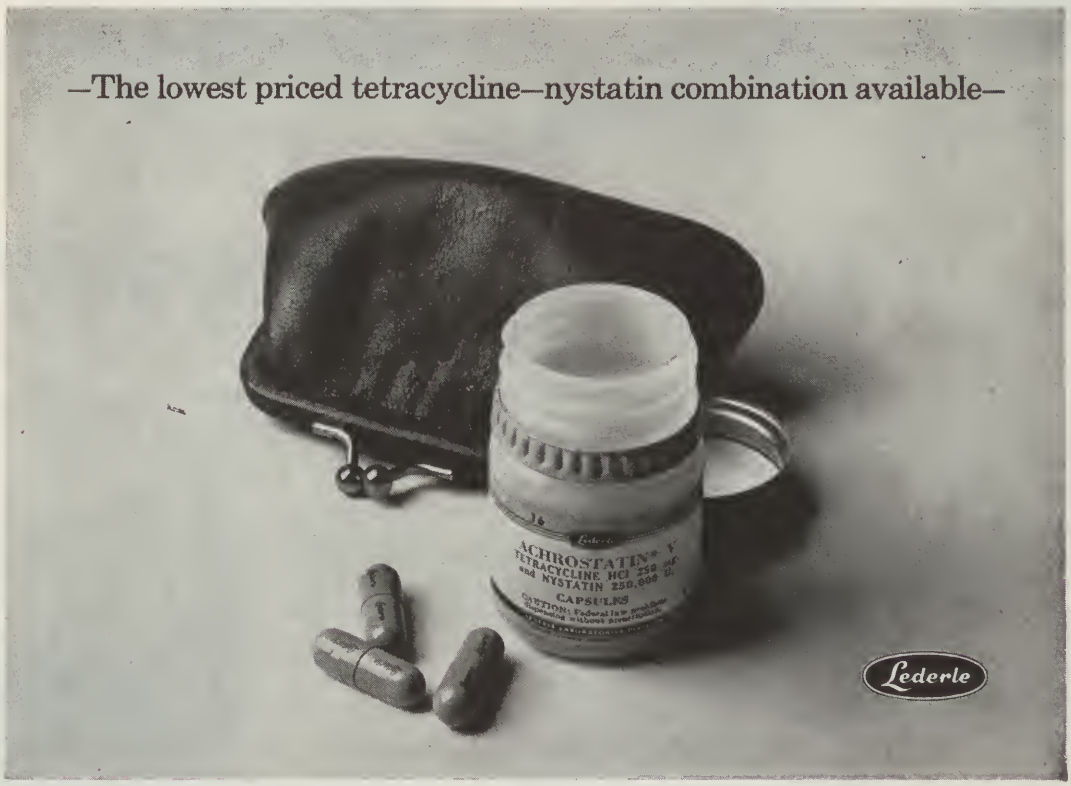
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A Volunteer Physician's Experiences in Vietnam

ANDRE FESUS, MD
Baltimore

It is amazing to me how little publicity and attention is given by the media to physicians, even when they are doing altruistic, philanthropic work. In the newspapers you see headlines about the cruelties committed by Americans in Vietnam, but very little, or nothing, about the benefits of the AMA Volunteer Physicians for Vietnam program that supplies medical care to the poor civilian population suffering from the effects of a guerilla war. During the last three years, while the program has been in effect, over 800 physicians have served for a period of two months in the provincial hospitals of Vietnam. My son, who served for one year in Vietnam as a Pacification Officer, confirmed that the AMA Volunteer Physicians for Vietnam program is the most successful program there.

We physicians are privileged people. We can come in contact with all segments of the population, in all countries of the world, and can give them our services promptly.

When I arrived in Vietnam, an Army helicopter dropped me in Vinh Long at nine o'clock in the morning; two hours later I started with the clinic; and at 2:00 PM I performed my first operation. Daily, I saw about 60 patients and performed four major operations. One third of the operations were on war injuries—metal fragments from booby traps, mortar shells, and mines. On my first day in Can-Tho we treated the survivors from a civilian bus that was mined on its way to the market, a route untraveled by military personnel—Vietnamese or American. Fourteen people were killed on the spot. Vietcong terrorists attack everywhere, especially where crowds are gathered. One Sunday I walked to the market in Vinh Long and stopped to take photos from the veranda of a restaurant on the bank of the Mekong River. While watching the crowd, which was composed only of women and children, it struck me that this would be a perfect place for a terrorist bomb. Two hours later a bomb went off at that exact spot and 12 people were killed. Twelve others were seriously injured. This is immoral war!

During the TET offensive the Hue University Medical School's German professors and their families were slaughtered by the Vietcong. The press reported very little, or nothing, about these martyrs of medical science, and no pacifist groups ever protested against this massacre. The Vietcong allege that the South Vietnam population is of communist sentiment. Why then are they systematically killing innocent children and women? The answer is clear—the communist doctrine teaches that with terroristic intimidation of the masses, the power can be seized by a well organized 3% of the population.

The Vietnamese are a friendly and warm people. They are worthy of respect. Dignity, restraint, and politeness are highly regarded, and love and respect for one's parents and elders are emphasized. The difference of one year in graduation among physicians dictates a lifelong filial respect of the younger for the older. Were that only true here!

Children everywhere are lovely, but they are particularly handsome in Vietnam. Although endemically shy, when something curious comes by, like an American, they draw closer for a better look. A great fascination is the hair on our forearms, which they like to stroke and tweak. When they are rewarded for a captivating smile by an American, they call him "Number One". When they are ignored, the American is mocked by "Number Ten, Number Ten".

The Vietnamese women are, on the average, very pretty and very slender. Unlike the flabby women of India and Pakistan who can hide their ample figures under the sari, the Vietnamese women wear

tight form-fitting blouses and hide their thin bodies with long sleeves and trousers. This national dress, the Ao-Dai, is a slit "maxi-tunic" over pants, is kept spotlessly clean and is worn everywhere, even while riding a motorbike, or when walking in muddy roads during the monsoon season. The back half of the tunic is clipped in the luggage rack and the front half is held on the handlebars of the bike. The women move gracefully in their elegant dress, whether walking in the street, planting rice in the paddyfields, or carrying an enormous weight like gallons of water.

Almost the entire male population of Vietnam has been conscripted into the army. There are 1,400 Western educated physicians. Only 400 of these are civilian physicians, who care for the population of 15 million. The rest, as well as all new graduates from medical schools, are enrolled in the armed forces.

In Vietnam, a patient first goes to see a Chinese doctor who cures everything with mysterious herbs and pinches the skin around the ailing organs, causing hematomas. Another Chinese speciality is "Acopuncture", or driving long needles through the various parts of the body. I read recently in the *New York Times* that the infallible Mao Tse Tung ordered this method to be perfected to the point where patients born deaf and dumb, upon their cure, exclaimed spontaneously, "Long live Comrade Mao".

My own exposure to Chinese medicine was less successful. One day I walked into the Can-Tho hospital and rushed to the emergency room, where I found a two-week-old moribund child with symptoms and signs of general sepsis. After two labored breaths, within a minute, the child died. (Newly-born children are wrapped in warm clothes, a custom indoctrinated into uneducated people by witch doctors.) I unwrapped the corpse and found an oozing spina bifida, large as a fist, richly covered with some dirty salve, which obviously had transmitted the infection.

Vietnamese people in the Mekong Delta are remarkably healthy. In two months I did not see any congenital ailments or overweight people. I saw one diabetic retinopathy and only two retinal hemorrhages due to hypertension—just as much as I saw in private practice as an ophthalmologist the first week I was home. I had no cases of arthritis—even old people are erect in spite of hard labor. The people in the tropics are constantly exposed to all kinds of infection, but they develop immunity to various diseases.

Hospitalization is free, but there is a constant critical shortage of hospital beds. "Semiprivate" in Vietnam means two or three patients in one bed. The shortage of beds is somewhat alleviated by the local custom of surrounding the patient with all his relatives by day. At night, his relatives take him to their home. Next morning the patient returns with his relatives to the hospital. There are model hospitals like the Rehabilitation Center in Saigon, which unfortunately is receiving more and more patients with amputated legs or those who are blind.

Vietnam has a very old civilization with roots in Asian religions and philosophies. The Vietnamese people fought for national independence from colonialism, but their modern civilization and culture is strongly under French influence. The most famous TB specialist, who is always wearing the ribbon of the highest Vietnamese decoration, awarded for his fight against the French, told me proudly, "My culture is French et j'étais capitain de l'armée francaise." When the French names of the streets in Saigon were changed or abolished, only two were saved, that of Pasteur and the other of the French missionary, a Catholic priest, who taught them the Latin alphabet.

The Vietnamese are proud people. They are fighting to preserve the freedom that they fought for 25 years ago, and which is now threatened by communism. They are not parasites. They appreciate foreign aid but, as the director of the Can-Tho Hospital said during a farewell party given for a very successful American surgeon, "We wish to be always independent, de n'importe qui, n'importe quel pays" (from no matter whom, no matter what country).

Obviously, you can tell that I had a good experience in Vietnam. In fact, I met intelligent and interesting people who were dedicated to their profession and to the liberty and independence of Vietnam. I feel fortunate that since I speak French fluently, I could establish a more intimate contact with the people than I would have otherwise.

In conclusion, not meaning to overestimate the value of the service rendered to the poor people of Vietnam, I have the moral satisfaction along with other volunteer physicians, of feeling proud of our humanitarian work which elevates us over the unpatriotic, selfish, spoiled cowards, "Sybarite" shirkers.

Fortunately, we have had no fatalities among the volunteer physicians. A few have been shot, but they recovered without being permanently wounded.

A young California colleague came to see us in Can-Tho. We took him to a pool, but he would not join us in a swim. Many weeks later we learned why he had declined. While delivering a jeep load of goods in Rach-Gia, which his wife had collected for an orphanage, he had been shot. He removed the bullet which had stuck in his ribs, and secretly dressed the wound himself to conceal the incident from his colleagues, and particularly from his own wife.

My last words are a quotation from Benjamin Franklin, whom I have admired since my youth. "I feel a better and happier man, I otherwise should have been, if I had not attempted it."

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brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The combined population of Dundalk, Annapolis, and Bethesda is 193,500. (Estimated 1969 figures from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

Outstanding results in serious gram-negative respiratory infections[1,2]

GARAMYCIN Injectable may prove successful where other antibiotics have failed.



Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]



Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Schering

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.
In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Pathogens	Percentage of sensitive strains Number of strains tested Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
	Antibiotics*							
Klebsiella pneumoniae	**99.5%** 962	**84.7%** 992	**86.2%** 995	**76.1%** 67	**32.7%** 1,020	**96.3%** 640	**82.9%** 1,028	**77.1%** 1,026
Aerobacter aerogenes	**95.9%** 2,739	**86.1%** 2,818	**53.5%** 2,985	**58.8%** 1,514	**22.7%** 3,066	**88.6%** 2,603	**85.8%** 3,071	**67.8%** 2,981
Klebsiella aerobacter group	**98.8%** 566	**83.9%** 547	**66.1%** 522	**60.5%** 276	**28.0%** 553	**89.5%** 560	**86.2%** 587	**62.8%** 433
Klebsiella, all others	**92.7%** 2,944	**83.3%** 3,186	**77.4%** 2,976	**67.5%** 627	**13.5%** 2,883	**95.0%** 2,105	**81.6%** 3,212	**70.6%** 3,063
Pseudomonas aeruginosa	**91.6%** 4,528	**29.8%** 4,460	**6.6%** 4,418	**6.6%** 1,279	**6.0%** 4,360	**91.3%** 3,852	**26.9%** 4,608	**26.4%** 4,404
Proteus, indole-positive	**91.8%** 1,031	**85.8%** 1,062	**39.9%** 981	**54.1%** 364	**40.2%** 1,042	**10.3%** 758	**76.1%** 1,096	**42.1%** 1,051
Proteus mirabilis, indole-negative	**94.9%** 3,272	**90.1%** 3,378	**83.1%** 3,290	**77.5%** 975	**78.0%** 3,274	**8.8%** 2,634	**85.9%** 3,469	**26.8%** 3,278
Proteus, unspecified	**96.2%** 1,335	**85.8%** 1,371	**71.7%** 1,434	**70.0%** 647	**64.7%** 1,435	**11.2%** 1,233	**76.0%** 1,421	**22.4%** 1,298
Escherichia coli and all other *Escherichias*	**96.4%** 12,557	**91.4%** 12,818	**87.8%** 12,686	**88.8%** 4,251	**74.6%** 12,899	**95.4%** 10,623	**94.1%** 13,086	**70.0%** 12,559
Paracolobactrum, all	**93.4%** 303	**88.9%** 325	**62.0%** 305	**74.2%** 62	**43.8%** 340	**80.9%** 215	**87.1%** 350	**72.6%** 340
Coliform bacteria	**99.0%** 593	**91.2%** 649	**81.5%** 637	**66.7%** 21	**52.7%** 624	**95.6%** 607	**91.6%** 678	**76.1%** 637
Totals	**95.1%** 30,830	**80.5%** 31,606	**65.3%** 31,229	**68.1%** 10,083	**50.3%** 31,496	**75.8%** 25,829	**79.7%** 32,606	**56.5%** 31,070
Gram-positive (Included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus,* coagulase-positive	**97.4%** 1,548	**88.8%** 1,458	**97.7%** 2,050	**98.7%** 636	**61.1%** 1,559	**20.4%** 628	**94.4%** 2,123	**83.7%** 1,966
Staph—*S. aureus,* unspecified	**99.3%** 993	**92.8%** 902	**98.1%** 1,289	**95.3%** 213	**45.8%** 1,153	**29.3%** 116	**96.4%** 1,427	**82.3%** 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[8]
Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.
Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.
Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.
It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable Garamycin®
brand of gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable Garamycin®

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those wh pre-existing renal damage, treated with GARAMYCIN Injectab usually for longer periods or with higher doses than recommend

GARAMYCIN Injectable is potentially nephrotoxic, and th should be kept in mind when it is used in patients with pre-existg renal impairment. Kidney function diminished by infection of e upper urinary tract may, however, improve during effective tre ment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such streptomycin and kanamycin or of potentially nephrotoxic dr such as polymyxin, colistin, and kanamycin with gentamicin sul e has not been shown to afford any clinical advantages and, morec may result in additive toxicity. Monitoring of vestibular, cochl and renal function will provide guidance for therapy in such ca

Precautions: In patients with impaired renal function in wh serious infection develops, serum concentrations of the drug r rise, with consequently increased risk of ototoxicity. In these tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine stu of kidney function should be performed when possible. These r be supplemented by evaluation of the vestibular and auditory fu tion and measurement of serum concentration of the drug wh feasible. Serum concentrations of gentamicin should be maintai below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to days or be repeated unless required for serious infection not sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injecta may occasionally result in overgrowth of nonsensitive organisms superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant a mals have not revealed teratogenic or ototoxic effects in the fe GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisa by the physician.

Adverse Reactions: The overall incidence of ototoxicity conside related to treatment with GARAMYCIN Injectable was 2.8 per c (16 of 565 patients). Contributory factors (two or more factors w relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently ceived other potentially ototoxic antibiotics (streptomycin or ka mycin), and 5 were over 60 years of age. Six also had decrea high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients sho increases in BUN that were probably related to treatment w GARAMYCIN Injectable. Of 20 increases probably or possibly rela to treatment, 7 were reversible, 9 occurred in terminal patients, a 4 had no follow-up.

Other adverse reactions associated with treatment were one insta each of urticaria, decreased hematocrit, and reversible depress of granulocytes with normal bone marrow. Other rarely repor and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotensi convulsions, twitching, salivation, nausea, vomiting, increased tra aminase activity (SGOT or SGPT), increased serum bilirubin, creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-d vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamicin gram-negative urinary and pulmonary infections, Arch. Int. M *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., a Smith, J. K.: Gentamicin in the treatment of pulmonary infectio J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a n aminoglycoside antibiotic: Clinical and laboratory studies in urin tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clini experience with gentamicin, data from 12 German clinics, in G tamicin: First International Symposium, Paris, January 19 Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Labo tory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nationw hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachus (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommen in Package Insert.

For more complete prescribing details, consult package insert Physicians' Desk Reference. Schering literature is also availa from your Schering Representative or Medical Services Departme Schering Corporation, Union, New Jersey 07083.

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Equipped for the thyroid emergency?

When an ambulance arrives with the unexpected patient presenting the classical picture of myxedema coma, is your hospital suitably equipped? It is if SYNTHROID® (sodium levothyroxine) injectable is at hand. You are also ready to conveniently handle post-operative thyroid medication situations until oral therapy can be reinstated.

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But in an emergency, when rapid replacement is needed to sustain life, prompt clinical response is essential. SYNTHROID injection makes this therapy instantly available. Is it available in your hospital?

Levothyroxine has a high binding capacity for serum proteins in contrast to other thyroid medicaments that may contain a thyroactive agent with low binding capacity. *The bound levothyroxine is totally measurable using the serum PBI test. It is not unusual to find PBI levels of 8-10 mcg. per 100 ml. of serum.*

INDICATIONS: SYNTHROID (sodium levothyroxine) INJECTION is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. It is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. When a patient does not respond to oral therapy, SNYTHROID (sodium levothyroxine) INJECTION may be administered intravenously.

PRECAUTIONS: As with other thyroid preparations, overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, insomnia and continued weight loss. These effects may become apparent in from 4 days to three weeks. Therefore, patients should be kept under close observation. Medication, in such cases, should be stopped for 2 to 6 days, then resumed at a lower level. In patients with diabetes mellitus, look for possible changes in metabolic activity which may affect insulin or other antidiabetic drug dosage requirements.

CONTRAINDICATIONS: Thyrotoxicosis, acute myocardial infarction.

SIDE EFFECTS: Side effects are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, weight loss, diarrhea, vomiting and nervousness. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. In most cases, a reduction in dosage followed by a more gradual adjustment upward will indicate the patient's dosage requirements without the appearance of side effects.

DOSAGE AND ADMINISTRATION: In myxedematous stupor or coma, with no evidence of severe heart disease, 200 to 400 mcg. of SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing a solution containing 100 mcg. per ml. Detectable effects are usually observed by the sixth hour after injection and are fully appreciated during the following day. A repeat injection of 100 to 200 mcg. may be given on the second day if significant improvement has not occurred. The intravenous use of sodium levothyroxine in myxedematous coma is advantageous because it produces a predictable increase in the concentration of protein-bound iodine, eliminates the need for multiple doses until oral therapy is reinstated, circumvents the uncertainty of oral absorption, and avoids the risk of pulmonary aspiration.

SUPPLIED: SYNTHROID (sodium levothyroxine) INJECTION is supplied in 10 ml. vials containing 500 mcg. of lyophilized active ingredient and 10 mg. of Mannitol, N.F.; a 5 ml. vial containing Sodium Chloride Injection, U.S.P. is provided as diluent.

Also supplied as SYNTHROID (sodium levothyroxine) TABLET in color coded compressed tablets, and in seven strengths: 0.025 mg. (orange), 0.05 mg. (white), 0.1 mg. (yellow), 0.15 mg. (violet), 0.2 mg. (pink), 0.3 mg. (green), and 0.5 mg. (blue). Each strength is supplied in bottles of 100 and 500 tablets.

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Recommended Faculty Policies

The Mediation Committee, at its April 27, 1970 meeting, voted to adopt the following policies with respect to publicity by physicians, and the solicitation of patients for research projects by hospitals, foundations, etc.

Guidelines for Physicians in Maryland Regarding Public Announcements

Article XIV, Section 1 of the Faculty's Bylaws are as follows: The Principles of Medical Ethics of the American Medical Association are adopted as the ethical standards of the Medical and Chirurgical Faculty of the State of Maryland and shall govern the conduct of members in their relations to each other and the public.

The AMA Principles of Medical Ethics is expanded by the Judicial Council Opinions and Reports. In these opinions we have the following:

13. RELATIONSHIP WITH COMMUNICATIONS MEDIA

A. Each medical society should appoint a communications committee, or designate a responsible individual or individuals, whose duty shall be to provide the communications media with accurate information on all medical matters of interest to the public. This information should be given freely. The communications committee may also serve in an advisory capacity to all communications media and to all physicians of its society in questions involving relationship with the media. To assist the media in obtaining information, medical societies may furnish the media with a list of names of physicians from whom authoritative information may be obtained, or a designated individual may serve as liaison between the media and the profession and furnish names of physicians to provide authoritative information when required.

These spokesmen may be quoted by name and title. This should not be considered by their colleagues as seeking publicity, since it is done in the best interest of the public and the profession. They may ethically provide appropriate information regarding medical and public health matters which have been discussed in technical papers or during medical meetings.

The officers, committee chairmen, and designated spokesmen of medical societies should be available at all times to bona fide representatives of the communications media in order that authentic information may be obtained as soon as possible.

* * *

D. Publications of photographs of physicians, who appear before recognized medical organizations, either in the official program of the scientific meeting or before the public press in connection with such meeting, is permissible. The use of photographs in the press when physicians are elected to office or when physicians are quoted by name on matters of general interest, not related to the care of a specific patient, is likewise permissible. Photographs of physicians in connection with civic or social affairs, not related to medical news or the care of patients, may be published unless the frequency of such photographs bespeaks self-exploitation. This applies also to magazine articles. Physicians should clear such publicity, whenever possible, with their county society.

E. The promise of radical cures or boasting of extraordinary skill or success is considered unethical by the medical profession because it is contrary to the best interest of the public.

F. For the purposes of clarity, the following principles should guide physicians who appear on TV or radio programs or who are interviewed in other media of public information, such as newspapers and magazines:

a) Doctors of medicine are expected to refrain from sponsoring products directly or by implication.

b) When introduced as a doctor on TV or radio programs, or quoted in an article as a physician in newspapers and magazines, such individual cannot escape the implications of representing the medical profession and his conduct should be in keeping with the high standards of the profession.

c) Sound judgment, good common sense, and adherence to the Principles of Medical Ethics are expected of any physician when appearing on TV or radio programs, or in other media of public information, such as newspapers and magazines, in whatsoever capacity.

G. Members of medical society speakers bureaus, because of the very nature of their assignments, may

be interviewed or quoted by the communications media. This is not considered unethical conduct.

The members of these committees must be most circumspect and uphold the ideals of the medical profession.

H. At all times the doctor of medicine is expected to comply with the Principles of Medical Ethics. Section 10 of the Principles of Medical Ethics deals with relationships between physicians and the communications media. It says: "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community." The Judicial Council construes Section 10 as encouraging physicians to work with the communications media as an integral and important part of the principle of upholding the responsibility of the physician to society as a whole.

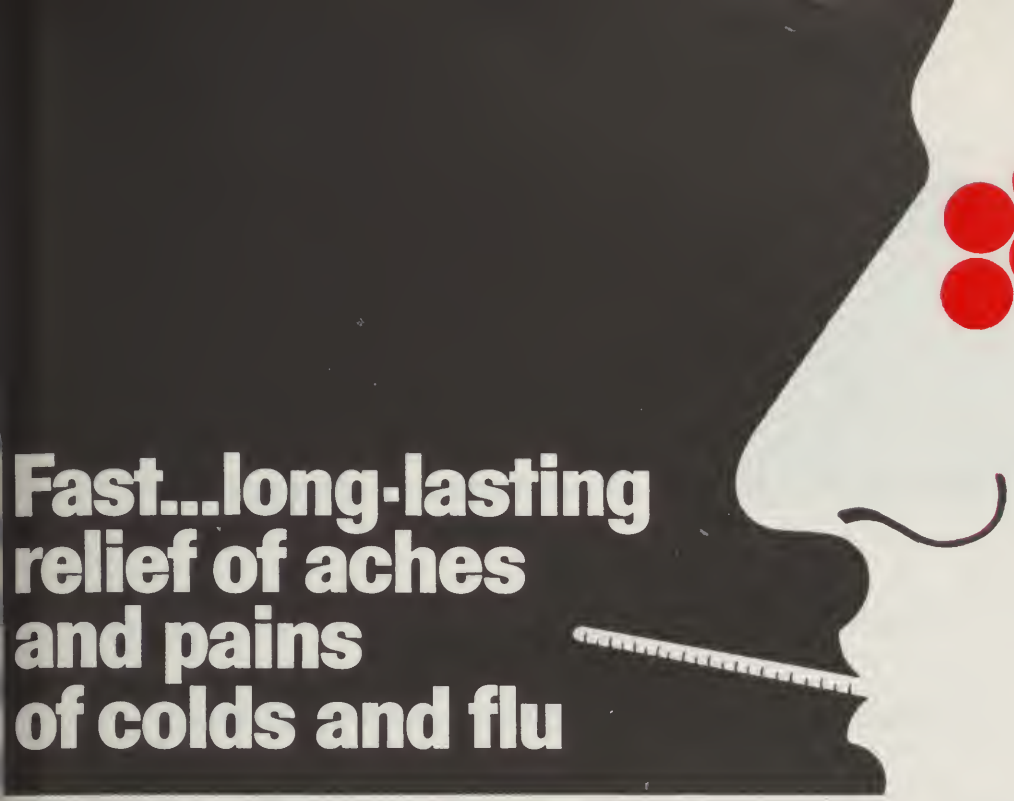
It shall be the responsibility of each county society to see that these Principles are not violated.

I. Doctors of medicine are ethically and legally required to protect their personal privacy and other legal rights of patients. The doctor-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of these media in every way possible.

Statement on Public Releases in Connection with Mass Screening Surveys and Research Programs

Recognizing the need for appropriate guidelines which individual professionals, voluntary health organizations, hospitals, nursing homes, and others should follow in connection with recruitment of volunteers for mass screening programs, research activities, and other related programs, the Hospital Council of Maryland, Inc., and the Medical and Chirurgical Faculty of the State of Maryland jointly subscribe to the following principles.

1. The right of the patient and the physician to maintain the best possible physician-patient relationship is paramount and no individual should be accepted into such a program without the consent and knowledge of the physician if he is undergoing active treatment.
2. Solicitation of individuals for recruitment into such programs should be done, insofar as possible, through the mechanisms of professional journals, hospital bulletin boards, medical staffs, etc. with full details being disclosed so that physicians can be informed as to the extent, purposes and objectives of such programs.
3. Solicitation may be through the mechanism of individual letters addressed to physicians urging the cooperation of the physician in referring patients for research projects.
4. If medication or treatment is provided to the patient, the attending physician should be kept fully advised so that, in the event he is to see the patient he will be aware of what is taking place with respect to his patient in the research project.
5. Full details of the care provided to his patient should be provided the physician on the completion of the research project. In the event any unknown condition is discovered through the research project, the patient should be advised to see his own physician for any treatment or care that may be necessary in this regard.
6. At all times, cordial relations should be maintained between the persons responsible for the research program and the physicians whose patients are being seen through this mechanism.
7. It is self-evident that patients in a research project should not have any facet of their care by their attending physician criticized or any doubt cast on such treatment.
8. In any event, each person participating in the project should be fully aware of his responsibilities and the responsibilities of his own attending physician and the physician in the research project.
9. No television or radio spot announcements should be directed to the public for recruitment of individuals for such research projects, except for mass screening surveys.
10. The use of normal "ballyhoo" type of promotions is strictly prohibited. This applies to banner-type streamers attached to aircraft, the use of sound trucks, amplifiers, and any type of activity that is normally associated with a circus-type atmosphere.



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Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

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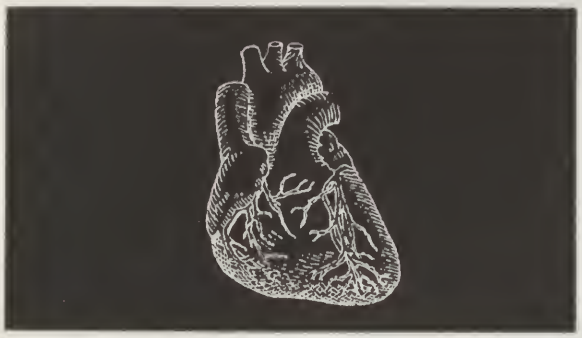
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MIRIAM L. COHEN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

The Use of Beta-Adrenergic Receptor Blockade in the Treatment of Cardiac Arrhythmias

BERTRAM PITT, MD
Assistant Professor of Medicine
The Johns Hopkins Hospital

Beta-adrenergic receptor blockade has been found useful in a variety of cardiac arrhythmias. Propranolol, the only beta-adrenergic blocking agent currently approved by the Federal Food and Drug Administration, is almost completely absorbed in the gastrointestinal tract. Its peak plasma concentration occurs approximately 90 minutes after oral administration. Excretion is predominantly in the urine.

Beta-adrenergic receptor blockade depresses the activity of the sinus node (by blocking the effects of endogenous catecholamines) resulting in a slowing of heart rate. Conduction is also depressed through the A-V node and ventricles.

Clinically available propranolol is a mixture of both dextro-(d) and levo-(l) isomers. Electrophysiological studies with pure preparations of these isomers have shown that propranolol, in addition to acting as a beta-adrenergic receptor blocking agent, has a quinidine-like effect on the heart. The effects of quinidine on the electrocardiogram differ from propranolol, however, in that quinidine increases heart rate, P-R interval, duration of the QRS complex, the Q-T interval, and causes inversion of the T wave, whereas propranolol slows the heart rate, has little effect on the P-R interval, shortens the Q-T interval, and increases the height of the T wave. Dextro-propranolol, a relatively weak beta-adrenergic receptor blocking agent, has been shown to be effective in the suppression of ectopic arrhythmias due to digitalis and anesthetic agents through its quinidine-like action, although it is relatively ineffective in controlling ventricular rate in rapid supraventricular arrhythmias. Levo-propranolol, a potent beta blocking agent, results in a slowing of ventricular rate in rapid supraventricular arrhythmias by inhibiting the effects of endogenous catecholamines on A-V conduction.

Propranolol is useful in controlling ventricular rate in patients with paroxysmal atrial tachycardia, while long-term oral therapy may reduce the incidence of recurrent episodes. Propranolol is currently the drug of choice to prevent supraventricular arrhythmias in patients with the Wolff-Parkinson-White syndrome by causing both antegrade and retrograde block at the A-V junction preventing a re-entry mechanism. Although digitalis is still the preferred drug for the control of ventricular rate in patients with rapid atrial fibrillation and flutter, propranolol is proving to be a valuable adjunct. Propranolol may be given intravenously in increments of 0.5 to 1 mgm to those patients in whom an intravenous digitalis preparation fails to adequately slow ventricular rate in the desired period of time. This increment of propranolol may be repeated every two to five minutes with careful monitoring of blood pressure and electrocardiogram, until the ventricular rate falls to an adequate level. The total dose required to achieve an adequate slowing of ventricular rate varies, depending upon the amount of digitalis administered,

patient sensitivity, and circulating catecholamine level. Most patients will, however, respond to a total dose of 5 mgm or less. It may prove safer to use small increments of intravenous propranolol to slow ventricular rate in these arrhythmias rather than risk the possibility of digitalis intoxication with large doses of digitalis, especially in situations such as the postoperative period. Similarly, oral propranolol in doses of 10 to 40 mgm qid in combination with digitalis has been found useful in the long-term management of ventricular rate in patients with atrial fibrillation. Propranolol has not, however, been found useful in restoring sinus rhythm in these patients. Beta-adrenergic receptor blockade with propranolol should not be used in those patients in whom these arrhythmias occur during the course of congestive heart failure, since the failing myocardium is particularly dependent upon beta-adrenergic stimulation for maintenance of adequate contractility. In those patients in whom the rapid ventricular rate precipitates or contributes to the manifestations of congestive failure, propranolol may, however, occasionally be used with extreme caution.

Beta-adrenergic receptor blockade has also been used in patients with atrial or ventricular arrhythmias due to digitalis intoxication where other measures; such as withholding digitalis and potassium administration, have failed. In animals with experimentally induced digitalis intoxication, propranolol has, however, occasionally produced profound bradycardia, enabling ventricular tachycardia to occur by an escape mechanism. Propranolol has been an effective agent in arrhythmias occurring during anesthesia, since these arrhythmias are often associated with elevated levels of circulating catecholamines. Propranolol should, however, be avoided during ether anesthesia since maintenance of adequate ventricular contractility is dependent upon circulating catecholamines in this situation. Propranolol is also effective in the control of tachycardia and arrhythmias in patients with phaeochromocytoma undergoing surgery. The combination of an alpha-adrenergic blocking agent such as phentolamine with propranolol has been used in the long-term management of patients with inoperable phaeochromocytoma.

Propranolol has been increasingly used in controlling ventricular rate in various hyperkinetic circulatory states including anxiety, hyperkinetic heart syndrome, and thyrotoxicosis. It has also been used successfully with refractory ventricular arrhythmias occurring during a variety of conditions including myocardial infarction. The risk of precipitating congestive heart failure in this situation outweighs the benefits in most instances. The introduction of newer, more selective beta-adrenergic receptor blocking agents without myocardial depressant effects may, however, prove useful in the therapy of myocardial infarction in the future.

In patients with impaired ventricular function, propranolol may intensify the manifestations of congestive heart failure as mentioned above and has led to profound hypotension and death since these patients may be dependent upon beta-adrenergic stimulation for maintenance of adequate cardiac contractility. Propranolol may also lead to profound bradycardia and, on occasion, complete heart block through its effects on A-V conduction. The drug should, therefore, be used with extreme caution in the presence of bradycardia and should be avoided in the presence of second degree or complete heart block. It should also be avoided in patients with bronchial asthma since beta-adrenergic receptor blockade interferes with the effects of endogenous circulating catecholamines on the bronchial smooth muscle. Some of the newer beta-adrenergic receptor blocking agents, not as yet released for clinical use in this country, have a greater specificity than propranolol and show promise of avoiding the bronchoconstrictor effects of propranolol while maintaining their effects on A-V conduction. Propranolol has also led to hypoglycemia and it should be avoided in patients receiving monoamine oxidase inhibitors or other adrenergic augmenting psychotropic drugs. The other side effects of propranolol are infrequent and rarely necessitate stopping therapy.

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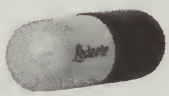
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...don't you think it's time we were on a first-name basis?

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Contraindications: Hypersensitivity to tetracycline.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

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I love my family.
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Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack]. Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel. Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

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MEDICAL NEWS

The federal Truth in Lending Act, which went into operation on July 1, 1969, has been clarified by a letter from Paul R. Dixon, chairman of the Federal Trade Commission, to Sen. Charles E. Goodell (R-N.Y.):

"The Truth in Lending Act does not come into play in a situation in which the patient decides on his own to pay his bill in installments. However, when a physician comes to a specific agreement with a patient to pay the physician's fee in more than four installments, then (the regulation) requires written disclosure of all *applicable* points of information at the time of the agreement. This will . . . be a very simple matter. . . .

"The following brief disclosure would satisfy the Truth in Lending Act:

Cash Price (Medical Fee)	**$500**
Less: Cash Down Payment (Advance Payment)	**100**
Unpaid Balance	**400**
Amount Financed	**400**
FINANCE CHARGE	**NONE**
Total of Payments	**400**
Deferred Payment Price	**500**
ANNUAL PERCENTAGE RATE	**NONE**

Purchaser (Patient) hereby agrees to pay to Dr. John Doe at the address shown above the "TOTAL OF PAYMENTS" shown above in 10 monthly installments of $40, the first installment being payable ..... 19...., and all subsequent installments on the same day of each consecutive month until paid in full."

The two items, FINANCE CHARGE and ANNUAL PERCENTAGE RATE, must appear in bold-face type or otherwise conspicuously, AMA attorneys emphasize.

According to Dixon's directive, the "use of the above form could be effectuated by any physician's nurse in a few moments and no other disclosure is required on subsequent billings."

(Excerpted from *American Medical News,* October 13, 1969.)

* * *

The Social Security Administration has recommended that the Justice Department bring civil suit against four extended-care facilities and a two-hospital corporation for the return of wrongfully collected Medicare payments, Robert M. Ball, Commissioner of Social Security, announced recently.

The five civil suit cases were referred to the Justice Department after evidence was found that the institutions, located in New York, Florida, Arizona, and Illinois, had collected overpayments amounting to approximately $2,257,600.

In a series of "validation" visits begun in March 1969, on-site inspections of institutions participating in the Medicare program were conducted to check on the validity of payments made by Medicare intermediaries. These program validization visits were supplemental to the regular contract performance reviews the SSA conducts in the offices of the intermediaries such as Blue Cross, Blue Shield, and private insurance organizations which receive and pay Medicare bills under contract to the SSA.

Commissioner Ball noted that one out of every 12 elderly persons discharged from a hospital, but still needing skilled nursing care on a continuous basis, is admitted to an extended-care facility under Medicare. There are about 40,000 such admissions every month, after an injury or illness requiring hospitalization for three days or more.

The average Medicare post-hospital stay in such a facility averaged 50 days in 1969 and payments totalled between $400 million and $450 million for the past calendar year.

To assist the Medicare contractors, the SSA has provided data that helps them to quickly identify irregular practices and costs. The identification of an institution which bills for what is indicated to be an unusual amount of physical therapy may reveal that services are being provided, and paid for, without regard to their medical necessity, and even their potential harm to elderly patients. An abnormally large number of bills for physician visits to patients in extended-care facilities may uncover a practice of "gang" visits to individual patients, but in fact reports so many visits for a given day that he could not have done more than stop by the bed.

The SSA has also developed information that will enable the Medicare contractors to be alerted when a physician is receiving payments for more services than he would likely be able to perform in normal practice. If computer data and investigation show this to be a problem, these organizations enlist the help of medical societies to take corrective action.

* * *

In his presidential address to the AMA House of Delegates in December, Gerald D. Dorman, MD, stated "the AMA can serve the best interests of physicians only when we serve those of the patient first. We are banded together to make ourselves more effective physicians so that we can serve our patients better."

He emphasized that "In the decade ahead (a decade he titled 'The Significant Seventies') the AMA must become—and prove to the public through visible action that it has become—more patient oriented."

In so doing, he said, medicine must take on the challenges of problems such as the alcoholic, the drug user, the fat man, the smoker, and the drunken driver.

Dr. Dorman added that meeting all of the problems calls for a "separate, cabinet-ranked department of health, drawing together all health activities of the government under one roof."

Regarding the AMA itself, the president said the Association has concentrated on being an organization for the physician in private practice. Now, he added, it must strive to attract physicians who are educators, researchers, administrators, and in federal service.

Another segment of the medical profession that must be attracted is the future physician. The AMA must find ways "to attract medical students, interns, residents, and other young physicians." Anticipating objections, he said, "We need to face up realistically to the fact that although we don't like the criticism of some of the younger members and would-be members of our profession—and perhaps we don't approve of the leftward lean of some of their politics—these young professionals are nonetheless as much, or more, patient oriented than some of us."

To accomplish the AMA's goals, Dr. Dorman warned, "We may have to alter certain of our cherished traditions. We must be prepared to accept and support totally new ideas, whether we devise them or they are devised by somebody else, providing they work well after adequate trial."

* * *

A Memphis health executive stated recently that current ills affecting the Medicare program may be a result of some fraud and deceit on the part of physicians and providers, but that the real culprit in the escalating cost of Medicare is the Social Security Administration which has failed to provide direction and interpretation.

John A. DeCell, president of Medicenters of America, Inc., an organization which encompasses extended-care facilities across the nation, said that there has been a concerted effort by SSA to control utilization of benefits in less expensive areas of extended care, but no effective effort to cut down on the time a Medicare patient occupies the higher cost, acute-care hospital bed.

"Most health authorities agree that 40% to 60% of hospitalized patients do not need the care of a general hospital and could receive care in a less costly, specialized recuperative care facility . . . but there has been no incentive given by SSA to effect the transfer," DeCell said. "With the current hodgepodge of regulations and interpretations, the physician finds it much simpler to leave the patient in the hospital where he knows that Medicare will pay the bill . . . until SSA comes up with meaningful guidelines both for hospital and extended-care coverage, there is going to continue to be waste and lack of control. . . . It is our feeling that a total re-evaluation of the aims and objectives of the Medicare Law should be made and guidelines established before sweeping changes are made that can cause more chaos in our health delivery system."

* * *

Robert W. Gibson, MD, medical director of the Sheppard and Enoch Pratt Hospital, has been elected vice president of the National Association of Private Psychiatric Hospitals.

* * *

Watts R. Webb, MD, a 1945 graduate of The Johns Hopkins University School of Medicine, has been appointed head of the department of surgery at the Upstate Medical Center of the State University of New York.

Other medical school graduates who have been named to new posts include **Joseph W. Gardella, MD,** of the class of 1944, who is now dean of students at Harvard Medical School; **Lewis W. Bluemle, BA '43, MD '46,** who has been installed as president of the Upstate Medical Center of the State University of New York; and **William A. McGovern, Jr., MD,** class of 1959, who recently became an associate director of clinical research at G. D. Searle and Co., Chicago.

* * *

James H. Semans, MD, of The Johns Hopkins University School of Medicine's class of 1936, has received the National Brotherhood Award from the National Conference of Christians and Jews. He shares the award with his wife.

Dr. Semans was a member of the medical school faculty from 1937 to 1943.

* * *

A newly elected member to the Wisdom Hall of Fame is Landrum B. Shettles, MD, PhD.

The award cites Dr. Shettles as being "a distinguished and admirable American of high ideals, real intellectual integrity, and true wisdom."

Dr. Shettles received his PhD in zoology from The Johns Hopkins University in 1937, his MD from the school of medicine in 1943, and was a member of the medical school's faculty from 1939 to 1944.

* * *

Leonard J. Gallant, MD, of Baltimore, was invited to conduct a seminar in Hong Kong on the topic "Sex Education for Adults?" The seminar was held on May 5 in conjunction with Queen Mary Hospital of Hong Kong Island and the Southern Medical Association.

* * *

George E. Urban, Jr., MD, of

Silver Spring, recently became a Diplomate of the American Board of Otolaryngology.

* * *

Recently certified as a Diplomate of internal medicine, by the American Board of Internal Medicine, is **Jamshid Hamed, MD,** of Towson.

* * *

Elliott M. Berg, MD, Arthur R. Jasion, MD, and **Stanley A. Klatsky, MD,** all of Baltimore, were recently certified by the American Board of Plastic Surgery.

* * *

One of the recipients of the 1970 Mead Johnson Awards is **Clifton A. McClain, III, MD,** from the University of Maryland Hospital in Baltimore.

* * *

A list of obstetric-gynecologic related graduate fellowships has been developed in the ACOG Administrative Office. The list contains subject, location, length, stipend, degree of clinical teaching, and research responsibility, and other information in tabular form. It is intended for the use of Fellows or Junior Fellows, Directors of Residency Programs, and others interested in existing and available fellowships. More than 90 fellowships covering the major fields of specialized study are included.

Copies may be obtained by writing: Fellowships, Communications Department, ACOG, 79 West Monroe Street, Chicago, Illinois 60603.

* * *

A group of physicians in the Baltimore metropolitan area, in the practice of Hospital Liaison Psychiatry, have organized the **Baltimore Association of Liaison Psychiatrists.** Elected as officers of the Association are: **Bernard R. Shochet, MD, President; Leonard Hertzberg, MD, Secretary-Treasurer; and Samuel Blumenfeld, MD, Program Chairman.**

* * *

Carl F. Weber, president of Lutheran Hospital's Board of Governors, has announced the election of James H. Shell, Jr., MD, as President of the medical staff at the hospital.

Dr. Shell was an assistant resident in surgery at the old West Baltimore General Hospital in 1948. He served as a resident at the University of Maryland Hospital from 1948 to 1951. He is now chief of gynecology at Lutheran Hospital.

* * *

Four Baltimore physicians were recently honored by the American College of Physicians at its annual meeting in Philadelphia.

W. Barry Wood, Jr., MD, and Ephraim T. Lisansky, MD, received the honorary degree of master. **Theodore E. Woodward, MD,** was presented the James Bruce Memorial Award for his work in preventive medicine. **John Imboden, MD,** was elected to an honorary fellowship.

Dr. Woodward is Professor of Medicine and head of the Department of Medicine at the University of Maryland School of Medicine, while Dr. Lisansky is Associate Professor of Medicine and Psychiatry there. Dr. Wood is Professor of Microbiology and head of the department at The Johns Hopkins School of Medicine, and Dr. Imboden is Associate Professor of Psychiatry at Hopkins.

* * *

William P. Houpt, MD, of Bel Air, was recently installed as a Fellow of the Industrial Medical Association in ceremonies marking the organization's 55th annual meeting.

The Association is an international organization of physicians who provide health care for the employees of private enterprises, governmental services, or other institutions. Association membership in the U.S. and 31 foreign countries exceeds 3,800.

* * *

The American Board of Anesthesiology has recognized the following physicians as Diplomates: **Robert R. Hylton, MD,** of Camp Springs; **Edward P. Juras, MD,** of Rockville; and **Peter B. Kane, MD, Allan L. Smith, MD,** and **Robert K. Stoetling, MD,** of Bethesda.

* * *

Gilbert D. Barkin, MD, of Silver Spring, has been appointed to the Board of Directors and to the Board of Governors of the American Association of Certified Allergists.

* * *

Solomon H. Snyder, MD, has received the John Jacob Abel Award of the American Society for Pharmacology and Experimental Therapeutics. The award, the Abel medal and $1,000, recognizes outstanding work in the field of drugs by an individual under the age of 36.

Dr. Snyder, 31, Professor of Pharmacology and Experimental Therapeutics, and Professor of Psychiatry at The Johns Hopkins University School of Medicine, received the award at the society's annual meeting in Atlantic City. He is the first member of the Hopkins faculty to receive the 20-year-old award.

Dr. Snyder was cited for "significant contributions that will lead to more certain recognition and predictability of the action of hallucinogenic drugs and more efficacious management of Parkinsonism and mental illness."

* * *

(Continued on page 72)

THE MONTH IN WASHINGTON



The American Medical Association urged that Congress appropriate as much money as possible for medical education to help "meet the pressing need which exists today for an increased number of physicians."

Testifying before a House appropriations subcommittee, C. H. William Ruhe, MD, director of the AMA's Division of Medical Education, said the association recognized the need for an overall reduction in federal spending to combat inflation.

"In view of this," he said, "we believe that in any appropriation priorities established for all government programs, those which affect health care should be given primary consideration. Further, because of the special need that exists at this period in our history for more physicians, we urge that appropriations relevant to the production of physicians be given first priority."

Dr. Ruhe pointed out that funds had not been appropriated for a backlog of approved applications for construction of facilities for new medical schools and expansion of existing schools as authorized by the Health Professions Education Assistance Act, the Health Research Facilities Construction Act and the Medical Library Act. He also said that full funding, in the amounts authorized by the Health Manpower Act of 1968, is necessary to permit construction of new and expanded facilities before major enrollment increases in medical schools will be feasible.

"The provision in the Administration budget of funds for the Physician Augmentation Program and for special improvement grants has been a considerable incentive to medical schools to expand enrollments," Dr. Ruhe said. "But many schools have already increased their enrollments to full capacity in their existing facilities. Others have been in serious financial distress and are in desperate need of increased operational support to maintain their present enrollments or even to survive. It must be recognized that such schools will need further facilities and operating funds which are necessarily tied to increased enrollments."

The subcommittee's hearings were on appropriations for the 1971 fiscal year beginning this July 1.

Using funds appropriated for the current fiscal year, 1970, the Department of Health, Education and Welfare recently announced nearly 300 grants to schools of medicine and other health professions totalling more than $54 million.

About $7.6 million went to 27 schools of medicine and osteopathy under the Physician Augmentation Program. A government spokesman said the grants would enable the schools to increase their first-year enrollment by 395 students.

About $46.5 million in institutional grants was allotted to 260 schools in the health professions—medicine, dentistry, osteopathy, podiatry, optometry, pharmacy, and veterinary medicine. These funds also will enable the schools to add more students through purchase of new teaching equipment, improvement of the physical teaching environment, purchase of supplies, books and periodicals, and other expenditures to improve the education of students.

* * *

The American Medical Association supports extensions of the Regional Medical Programs and, with some reservations, the program for Comprehensive Health Planning and Public Health Services.

Testifying before a House Public Health and Welfare Subcommittee, Bland W. Cannon, MD, Memphis, Tenn., a member of the AMA's Council on Medical Education, emphasized that the AMA believes that RMP "should continue as a program of continuing medical education, with patient care being limited to demonstrations as an adjunct of the education and research processes."

He said the AMA opposes legislation that would combine the individual programs.

"These programs are relatively new and we believe should be evaluated, as well as allowed to develop further evidence of their individual strengths and weaknesses," he said.

Dr. Cannon pointed out that the AMA House of Delegates last December affirmed its support of the concept of Regional Medical Programs and urged AMA members to participate at all levels in giving guidance to implementing the programs.

The AMA supports broadening the scope of the programs to include "other major diseases", in addition to heart disease, cancer and stroke, he said.

He said a combination of the programs would result in a change toward emphasis on patient care in RMP.

"We would view with grave concern any attempt to change this essentially educational program to a program for the provision of health services," Dr. Cannon said. "The medical profession today generally views RMP as a means of aiding the physician to provide better care to his patients. It is this attitude which has brought about the outstanding cooperation between practicing physicians and RMP, and which has been a major cause of success for the program thus far. If RMP returns to an earlier concept of providing services to the patient, rather than its present goal of assisting the individual physician to treat the patient more effectively, this cooperation will, in many cases, be lost. The program's beneficial accomplishments will then be diminished."

* * *

The American Medical Association supports, in general, legislation (S. 3835) that would provide a comprehensive federal program for the prevention and treatment of alcohol abuse and alcoholism.

Marvin A. Block, MD, Buffalo, N.Y., a member of the AMA's Committee on Alcoholism and Drug Dependence, termed the measure "a major landmark in public policy" in the field.

"It sets forth the proposition that alcoholism is an illness which can and should be treated, and it commits national resources to the establishment and coordination of facilities necessary for treatment and rehabilitation," he said at a hearing of the Senate Subcommittee on Alcoholism and Narcotics. "We are in general agreement with this legislation."

The bill would establish a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism. The Health, Education and Welfare Secretary, acting through the institute, would be required to submit within one year a detailed federal program, develop model programs for states, and conduct research and educational programs. Federal grants would be authorized for prevention, treatment and rehabilitation facilities and programs at the state and local level.

Dr. Block specifically favored several of the bill's provisions, including one that treatment and control programs should be community based, whenever possible.

"Insofar as it is feasible and economically sound, most alcoholics should be treated in their own communities and not be relegated to a distant centralized institution for treatment," he said.

But the AMA spokesman questioned some other provisions. He saw no need for a new institute. He said the present National Center for Prevention and Control of Alcoholism could perform the proposed institute's duties and responsibilities.

He said the AMA also questions whether alcoholics should be made eligible for welfare cash benefits and for health care under other government programs, such as medicare and medicaid, on the ground that they are alcoholics.

Noting that the legislation is concerned mainly with operation of programs by public and voluntary agencies, Dr. Block said:

"We should not overlook, however, the role that the private physician has played, and can play, in this important area. More and more, the physicians of this country are facing up to the problem of alcoholism in their daily practice. They are recognizing that, as difficult as alcoholism may be, it is an illness which can be dealt with, and that they can help their patients in cooperation with other professionals in the community."

The bill was introduced by Sen. Harold E. Hughes (D., Iowa), a recovered alcoholic and chairman of the subcommittee, and 37 co-sponsoring senators.

* * *

L-dopa, a new treatment for Parkinson's disease, has been approved for general prescription use, but it may be several months before it is available in ample supply.

"Clinical tests conducted during the past several years by medical researchers and two major drug firms have demonstrated the usefulness of L-dopa in the treatment of this disease which now afflicts possibly a million persons," FDA Commissioner Charles C. Edwards, MD, said.

Approvals were granted to applications made by Hoffman-La Roche, Inc., and Eaton Laboratories Division of the Norwich Pharmacal Co., Norwich, New York. (Eaton's product, Dopar [levodopa], is now available.) Both firms conducted studies in animals and humans to establish the drug's safety and effectiveness. An analysis of these studies indicated that benefits to the patient outweigh the risks involved, the FDA said.

"However, the Food and Drug Administration will require both drug firms to continue research into the drug's long-term effects and make certain it is safe and effective for long-term use," Dr. Edwards said. "This is the first time that FDA has included such a requirement in a new drug approval."

In order to give a balanced picture, Edwards pointed out that: • Clinical studies have shown that approximately one third of the patients receiving L-dopa do not respond favorably; • Side effects have been reported in a majority of patients, some of them quite unpleasant and others even dangerous. Whether or not the use of this drug is justified in the very early stages of Parkinson's has not

been established; • Since Parkinsonism is a chronic disease, patients will have to take L-dopa for long periods of time. We don't know how these patients will react after 5, 10, or 15 years of treatment. Because of our limited knowledge of the drug's long-term toxicity, it is conceivable that it could reverse the benefit-to-risk ratio.

The name L-dopa comes from the initials of an amino acid, levodihydroxyphenylalanine. Dr. George C. Cotzias, of the Medical Research Center, Brookhaven National Laboratory in Upton, New York, was the first to demonstrate the usefulness of L-dopa at high dosage levels. Dr. Andre Barbeau, director of the Department of Neurobiology at the Montreal Clinical Research Institute, has been studying the new drug for the past ten years and is also credited with aiding in its development as a treatment for Parkinsonism.

* * *

Congress approved legislation extending the 24-year-old Hill-Burton federal-aid-to-hospitals program for three years with authorized expenditures of $2.76 billion.

The final form of the legislation was a compromise agreed to by House and Senate conferees after the two branches of Congress passed differing versions.

The authorized expenditures broken down are: $1.26 billion for various state grant-in-aid programs for construction and modernization of hospitals, and $1.5 billion for loan guarantees. The measure also authorizes funds to subsidize interest payments on loans up to 3%.

The legislation approved by the conferees followed the House version for the most part. The Senate had approved a five-year $6.2 billion bill. The conferees eliminated entirely a Senate provision for $750 million of direct loans for public hospitals, which was strongly opposed by the Nixon Administration.

Also knocked out was a Senate amendment for a new formula for allocation of federal funds in a way that would have benefited large industrial states. However, the Health, Education and Welfare Department was directed to make a study of possible formula changes and report to Congress in two years.

* * *

Two physicians and a management expert were appointed Deputy Assistant Secretaries for Health, three long-vacant posts in the Department of Health, Education and Welfare.

Thomas C. Points, MD, Oklahoma City, is deputy assistant secretary for Health Services. He is an alternate in the AMA House of Delegates and on the AMA Council on Health Manpower. As director of the Department of Preventive Medicine at the University of Oklahoma Medical Center, he helped establish the state's rural health project, "Project Responsibility".

LeRoy A. Pesch, MD, Buffalo, N.Y., deputy assistant secretary for Health Manpower, was dean of the School of Medicine at the State University of New York at Buffalo.

Gerald Riso, New York city, formerly with Booz, Allen and Hamilton, Inc., management consultants, is deputy assistant secretary for Policy Implementation.

Still vacant, in early June, were the posts of Deputy Assistant Secretary for Research and Development and for Environmental Health and Prevention of Disease Problems.

Morris E. Chafetz, MD, director of Clinical Psychiatric Services of Massachusetts General Hospital, Boston, was selected to succeed Jack Mendelson, MD, as chief of the National Center for the Prevention and Control of Alcoholism. Dr. Mendelson is returning to a teaching post at Harvard Medical School.

Two high-ranking officials left the HEW Department with critical blasts directed at their bosses.

Stanley F. Yolles, MD, said he quit as director of the National Institutes of Mental Health because the Nixon Administration had abandoned the mentally ill. HEW Secretary Robert H. Finch said he was fired because he was not cooperative. Dr. Yolles was succeeded by Dr. Bertram Brown who had been deputy director. Despite the dispute, Dr. Yolles will stay in HEW until November 1 as an assistant for mental health to Dr. Vernon Wilson, new director of HEW's Health Services and Mental Health Division. Dr. Wilson succeeded Dr. Joseph T. English who resigned quietly to take a high public health post in New York city.

Robert J. Myers, chief actuary of the Social Security Administration for 23 years, resigned with a charge that Social Security Administrator Robert M. Ball had attempted "to muzzle and intimidate me with regard to three speeches that I was making in support of the Nixon Administration's position on social security legislation." Ball denied it, and countered that Myers, who was supposed to be an objective career civil servant, had wanted to be a policy spokesman.

Myers had publicly accused Ball and other high SSA officials of being "expansionists" in the social security field with a goal of the federal government providing a retirement income level virtually as high as before retirement.

In a letter of resignation, Myers told Finch that these officials "have not—and will not—faithfully and vigorously serve the Nixon Administration."

* * *



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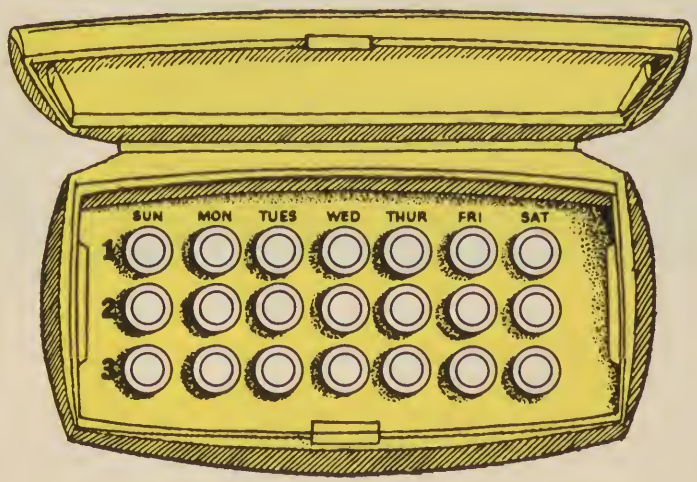
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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision.

Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

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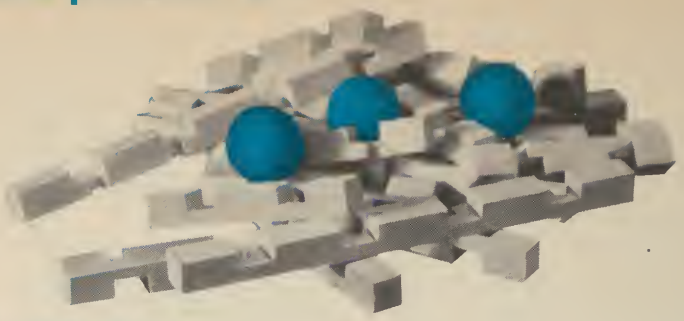
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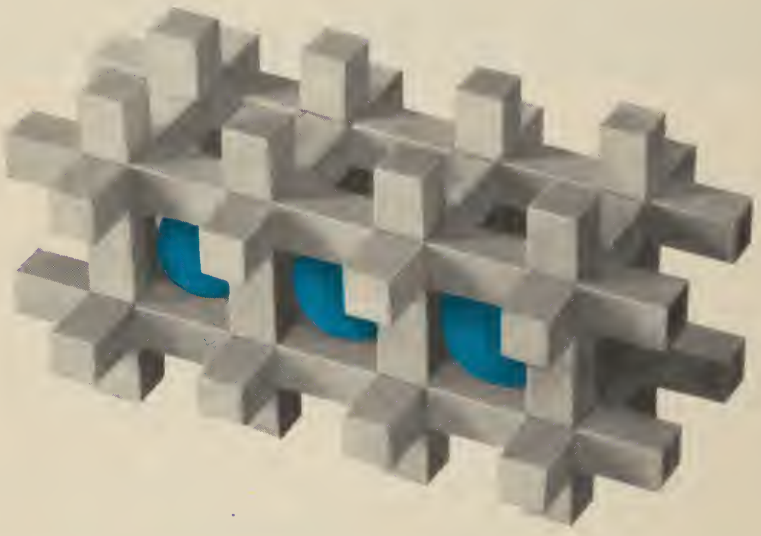
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References: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al: Hosp. Topics 39:71-73, 1961: (3) Haas, Jr., J., and Kay L.L.: Southwest. Med. 42:30-32, 1961 (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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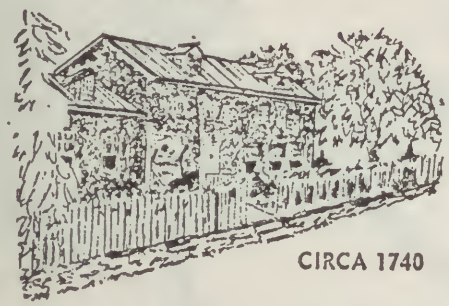
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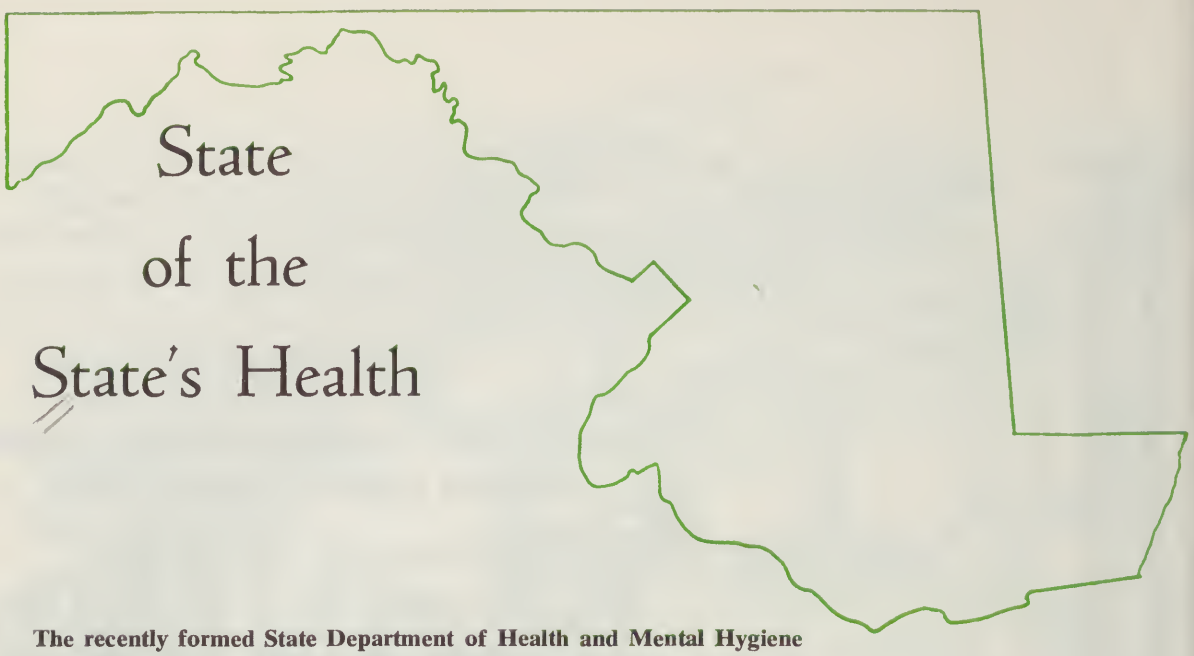
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State of the State's Health

The recently formed State Department of Health and Mental Hygiene was established in compliance with legislation passed by the 1969 session of Maryland's General Assembly and signed into law by Governor Mandel. On July 1, 1969, the department was activated.

The new organization encompasses the functions and responsibilities of the former State Board of Health and Mental Hygiene; the existing state departments of Health, Mental Hygiene, Juvenile Services, and Comprehensive Planning; and 127 commissions and major task forces concerned with medical and health activities in Maryland. To these, a Directorate for Mental Retardation Services and a Drug Abuse Authority, activated on January 1, 1970, have been added.

The new department has concentrated its efforts in five major areas: 1. developing a health program to provide protection against environmental pollution, preventable disease, and premature loss of life; 2. providing comprehensive health and medical services for the indigent; 3. providing inpatient and outpatient services for the chronically ill, mentally ill, mentally retarded, narcotic addicts, and persons with tuberculosis; 4. developing community-oriented programs of preventive and rehabilitative services for delinquent children; and 5. promoting better health care through special studies, research, and adequate health manpower.

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Health and Mental Hygiene and Scientific Affairs

Two of the principal determinants of a community's health attainment are its economic status and the level of cohesiveness of its families. Although Maryland ranks tenth in the nation in per capita income, economic advantages are not distributed uniformly. Baltimore city, for example, is a point of concentration of substantial poverty. In Western Maryland's Allegany and Garrett counties, and the Eastern Shore's Caroline, Dorchester, Somerset and Wicomico counties there are pockets of considerable poverty. Where poverty is entrenched, family stability tends to be weakened, and some conventional health problems will persist. Such health problems include a high incidence of tuberculosis, a relatively high rate of infant mortality and premature infants with associated defects, and a high incidence of nutritional anemia.

The previous pattern of public intervention in medical and health problems has been a succession of categorical programs such as tuberculosis control, acute communicable disease control, maternal and child health, control of chronic diseases, institutional care of the mentally ill, control of alcoholism, and narcotic addict control. There is reason to believe that we have reached a point in the multiplicity of such programs and to continue this

pattern would result only in inefficiency and ineffectiveness. At this time, there appears to be an overriding need to emphasize the value of providing a system of care for each family. Health and medical services should be delivered on an individual basis—such as the patient-family physician relationship. Only a steadily declining fraction of the population is able to benefit from such a relationship and the urban poor are not in this bracket.

In connection with its responsibilities for a medical care program for 280,000 indigent Maryland residents, the Department of Health and Mental Hygiene proposes to develop conditions which will afford the recipient easy access to the complex of services required to preserve a modern standard of health.

One of the truly impressive developments during 1969 was a decline in the incidence of tuberculosis from 1,094 cases reported in 1968 to 890 in the past year. This 18% reduction opens the way for a new phase in the strategy of handling this problem—a goal of eradication of this disease.

The examples of smallpox, diphtheria and poliomyelitis offer dramatic evidence of the possibility of eliminating disease. Measles soon will be controlled; undoubtedly, rubella and pertussis will follow the same course. The common factor in each of these examples is the availability of an active immunizing agent for which mass distribution is easily achieved. No such agent exists for tuberculosis, but the virtual elimination of typhoid fever and malaria are examples of diseases controlled without mass distribution of an immunizing agent.

The campaign against tuberculosis will be based largely on widespread use of chemoprophylaxis among tuberculin positive reactors, and disciplined use of chemotherapy among active and recently discharged patients. Because of the decline of the disease 400 beds have been released from the tuberculosis facilities of Baltimore City Hospitals and Mt. Wilson Hospital. It is expected that the 65-bed Pine Bluff Hospital on the Eastern Shore will also be converted to other purposes.

Rubella (German measles) can be a disastrous infection when it occurs among pregnant women. Congenital blindness, deafness, heart defects, and mental retardation are the more frequent permanent damages seen in live-born infants of mothers infected with rubella during the early phase of gestation.

During the 1964 rubella outbreak in Maryland, approximately 3,600 cases were reported. An estimated 1,400 infants among the 70,000 born that year were significantly handicapped, physically or mentally or both, because of their mothers' infection during pregnancy.

To prevent an epidemic of this disease, anticipated in 1971, a vaccine is available for mass inoculation at the cost of about $1 for each individual inoculated. It will be necessary to inoculate 900,000 young children between one and twelve years of age. It is estimated that 100,000 children already have been inoculated by private pediatricians and through programs conducted by the local health departments for children in the first three grades. The remainder of the children will be reached before October 1 of this year. Immunization of children is expected to prevent transmission to adults, thereby protecting pregnant women.

In spite of remarkable advances in medical science during the past two decades, many degenerative conditions continue to defy prevention. In 1968, lung cancer claimed 1,163 lives, 947 were males and, with few exceptions, the deaths were attributed to cigarette smoking. Automobile accidents resulted in 874 deaths in Maryland, and many of these were associated with intoxication.

Continuous public education programs by the local health organizations will aim to prevent such unnecessary deaths from lung cancer and alcohol. Deterrent penalties, such as revocation of licenses and incarceration, will be used against drinking drivers. The former permissiveness which characterized the treatment of such drivers cannot be tolerated as long as alcohol is a significant contributing factor in traffic fatalities.

Most of the illness and resultant disability is increasingly associated with chronic diseases. Three broad categories of causes, of critical importance to public health and medicine, include behavioral disorders, mental retardation, and degenerative illness among the aged.

Significant behavioral conditions include maladaptive behavior in very young children, aggressive behavior among school children, juvenile delinquency, narcotic addiction, alcoholism, adult psychoses such as schizophrenia, and the confused behavior of the aged. Such diseases are costly and maintenance entails 7,600 beds in the state mental hospitals; 2,500 beds in the voluntary, teaching, or private hospitals; facilities for 1,300 juveniles in the institutions managed by the Department of Juvenile Services; and an unknown number of beds in the nursing homes devoted to caring for the elderly.

Services must be provided early in the development of emotional disorder in an attempt to control the cost and disabling effects of such disorders. This can best be done within the patient's community, and public expenditures for institutional care, which have risen to prohibitive levels, instead can be aimed at the enrichment of community resources for such care.

The extent of involvement in the community's affairs may necessitate an informed and aggressive interest in the housing, educational and recreational opportunities of areas with a high rate of juvenile delinquency; a concern with the sources of supply of

narcotics where a problem of drug traffic among high school children is found; and possibly an interest in the development of social service programs for the aged. The involvement must be expanded to meet the increasing problems of emotional illness.

Mental retardation which requires publicly funded medical services affects two out of every 1,000 persons, or 8,000 state residents. In addition to the existing facilities—Rosewood and Henryton—the Washington Metropolitan Mental Retardation Center is under construction, and will contain 500 beds for the care of mentally retarded patients. An Eastern Shore Mental Retardation Center will also be built in 1971.

In addition to these facilities, 34 community day-care centers for the mentally retarded, throughout the state, care for children who cannot be accommodated in the regular school system. Presently, 900 retardates are receiving the training which will enable them to reach a level of self-care and independence previously considered unattainable.

To cope with this increasing public health problem and to correct the serious shortage of facilities for the mentally retarded, the Directorate for Mental Retardation Services, a new major administrative unit of the Department of Health and Mental Hygiene, was activated on July 1, 1970. This unit will manage long-term institutional care; community-based day-care and residential care; liaison with the State Department of Education on special education for the mentally retarded; and research, demonstration, and preventive services. In addition, measures are currently being taken to correct the serious overcrowding at Rosewood State Hospital.

The heaviest burden of illness falls on the elderly, who currently occupy nearly 15,800 beds in extended care facilities, skilled nursing homes, intermediate care facilities, chronic disease hospitals, and the state mental hospitals.

Although the prevention of all degenerative disease in the near future is certainly impractical, the elderly person must be given the means to adjust to his disabling condition in a way which encourages a maximum of independence while he remains close to his family and community. Hopefully, more home health services will be developed, and efforts to enhance the social life of the aged will be stressed. This includes adequate housing, assistance in nutrition, and an accessible source of medical services.

In an attempt to improve the environmental health within the state, pollution control facilities are rapidly being constructed. Twenty sewage treatment plants are planned throughout the state which will be partially funded by the state. An area of concern is the Chesapeake Bay. Although many of its tributaries show evidence of heavy pollution, the main body of the bay is of high quality. Pollution control will be aimed at such areas as the upper Potomac River, the Potomac estuary, the shellfish estuaries of the Eastern Shore, the Baltimore harbor, and Back River, all polluted by sewage, industrial wastes, acid mine drainage, or bacteriological contamination. With the help of the state's sewerage grant program, construction of facilities in these areas will continue.

During the past two years, and perhaps for the first time in the state's history, the trend toward steadily increasing water pollution has significantly been reversed. With continued public support, water pollution throughout the state will be substantially reduced.

Maryland's air pollution problems are most severe in the major urban centers such as Baltimore and the Washington area, but localized problems exist in many other parts of the state. Although the air pollution control program is still in a developmental stage, substantial results are being achieved. Recent evaluations were made on the 100 largest sources of air pollution in the state, with the development of a schedule of actions to bring them into compliance with new state regulations. So far, 20 compliance plans have been submitted for state review, and five have been approved.

Less progress has been made in control of solid waste disposal pollution, although several of the largest open-burning dumps have been abandoned or converted into sanitary landfills. There are still many facilities which are inadequate.

In Maryland, both the monitoring and regulatory control of radiation and pesticides are being strengthened. It is essential that the state's administrators have the authority to make and implement decisions on the control of these pollutants because of the gravity of the potential public hazard. Noise control is another area under study.

Conclusion

The time has come to coordinate the large number of personal health programs and services which exist in the public, private and voluntary sectors. The individual, his family, and society generally are served poorly when these services are administered in such a way that they compete for manpower with no consideration for priority, when the economic circumstances governing reimbursement are determined by third parties removed from the patient-provider relationship, and when the convenience of the patient may be a minor consideration in accounting for the location, timing, and organization of services.

The Medicaid program in Maryland will provide an opportunity to point the way toward more effective integration of the diverse public investment in the health services for the 280,000 residents of Maryland who are either on public assistance or in severely depressed economic circumstances.

Disaccharide Intolerance:

A Review for Practicing Physicians

It is well recognized that some patients experience gastrointestinal symptoms following the ingestion of milk. The first description of this clinical entity appeared in the early 20th century and was termed "fermentative diarrhea". In recent years, this syndrome has been clearly defined, with special emphasis on the pathophysiological features of this common problem.

Like many malabsorptive states, sugar intolerance has been abusively incriminated by some and totally rejected by others. Countless authors have investigated this syndrome and voluminously published their findings. It was felt that a review of the present concept of sugar intolerance would be of value to the practicing physician in his daily contact with patients.

It is the purpose of this paper, therefore, to review disaccharide intolerance with clinical pathophysiologic clarification and dietary management.

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Carbohydrates: Digestion and Absorption

Disaccharides and polysaccharides are the main sources of carbohydrates in natural foodstuffs. Disaccharides, as found in milk and milk products, provide approximately 35% of total carbohydrate intake. Polysaccharides, such as starch and dextran, yield the remaining 65%. In most instances, carbohydrates can be transported across the intestinal epithelium only as simple sugar or monosaccharide.[1-3] It is estimated that approximately 85% of total carbohydrate intake is composed of "other sugars", which require various molecular alteration prior to absorption.

Digestion begins in the oral cavity with mastication and the mixing of salivary amylase. The enzymatic role of salivary amylase in overall carbohydrate digestion seems relatively minor. Minimal or no additional sugar digestion is encountered until the food is exposed to pancreatic enzymes. Even after exposure to pancreatic enzymes, the resultant succus entericus contains a mixture of monosaccharide, disaccharide, and polysaccharide. At the present time, an isolated monosaccharide transport deficiency is not recognized in the absence of such overt intestinal anatomical distortion as seen in extensive regional enteritis,[4] celiac disease (gluten sensitive enteropathy), or extensive small bowel resection.[5] Likewise, defects in the intestinal intraluminal phase of digestion are not recognized for carbohydrates containing

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more than two monosaccharides, that is, polysaccharides. Therefore, our present understanding of sugar intolerance, as a clinical entity, is limited to the maldigestion of disaccharides.

The digestive process of disaccharides, for the most part, occurs during the intraluminal intestinal passage and is termed the intraluminal phase of digestion. This final phase of carbohydrate digestion is relegated to specific enzymes, disaccharidases. The greatest concentration of disaccharidase activity occurs in the micro villi of the matured intestinal epithelial cells (Figure I). It is felt that these enzymes are not secreted into the lumen of the intestine, but are confined to this anatomic cellular location, and are not only important in digestion but also initiate the first step in transepithelial disaccharide transport.[3] It is the failure of this intraluminal digestive phase of carbohydrates and concomitant failure of transport initiation which is responsible for the sequence of events manifested by patients suffering from "fermentative diarrhea" of disaccharide intolerance. As seen in other clinical expressions of enzyme deficiencies, disaccharidase deficiency may be either total or partial. The result is reflected as either complete or partial disaccharide intolerance. An acquired form of disaccharide intolerance may occur when the cellular "turnover rate" is greatly enhanced, resulting in the appearance of immature epithelial cells at the absorptive surface, as in celiac lesions and other small intestinal inflammatory lesions (Figure II). An acutal deficiency is demonstrable in this group of diseases which should not be confused with allergic modalities.

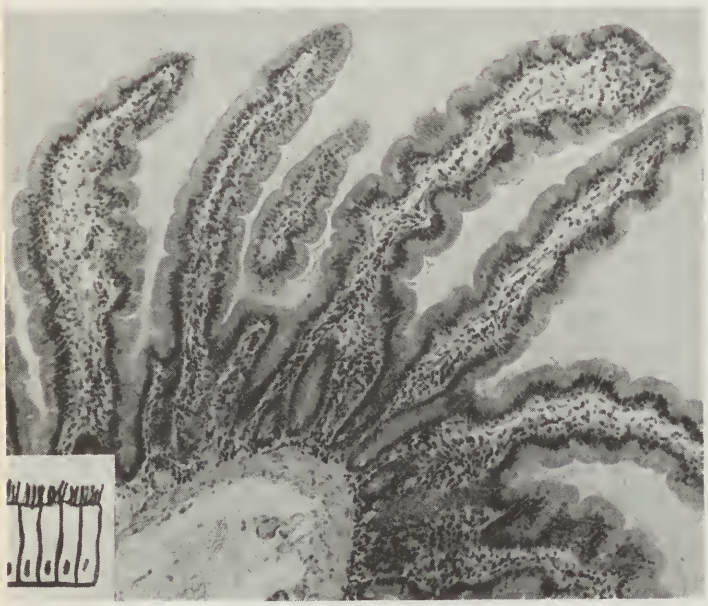


Figure I: Normal small bowel biopsy, showing a mature epithelial cell containing disaccharidase in the micro villi



Figure II: Abnormal small bowel biopsy (celiac) showing immature epithelial cell without micro villi, disaccharidase deficient

These enzymes (disaccharidases) have been isolated and classified by Dahlqvist.[6-8] They include lactase, sucrase, trehalase, and several maltases. In man, all intestinal disaccharides are highly developed at birth, or shortly thereafter, and for the most part are concentrated in the jejunum and ileum. Lower concentrations are found in the duodenum, but none in the stomach or colon.[9] The highest concentration is present in the jejunum and proxymal ileum, as distribution of disaccharidase concentration activity has been shown in normal subjects (Figure III).

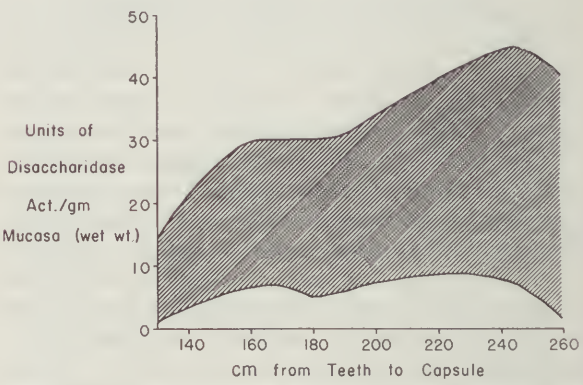


Figure III: Distribution of disaccharidase activity in normal subjects at various levels of the small bowel

The mechanisms that produce "fermentative diarrhea" occur as a result of nonabsorption of the disaccharide, causing intraluminal fermentation. The product of this intraluminal fermentation by the bacterial flora of the gastrointestinal tract has been described as noxious and irritating. The latter results in altered motility, absorption, and reflux of fluid into the intestinal lumen.[10, 11] This hypothesis is diagramatically shown in Figure IV.

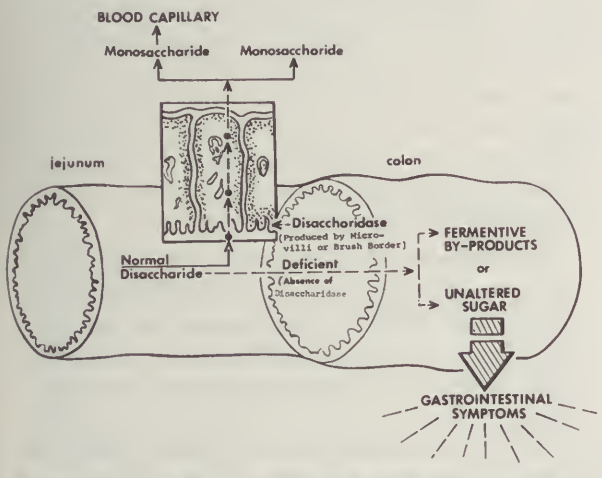


Figure IV: Normal and abnormal disaccharide absorption, resulting in altered absorption, motility and reflux of fluid into the intestinal lumen

Clinical Manifestations

Clinical manifestations presented by patients with disaccharide malabsorption due to intestinal disaccharidase deficiency may be congenital or acquired. The symptomatology and chronological occurrence vary with the age of the patient.[12, 13] Dietary habit in each age group determines the severity or cessation of symptoms. The mainstay of the diet in infancy is disaccharide; and since infants with disaccharidase deficiency have no means of rejecting this offending element, they will present with chronic, watery, acid diarrhea, dehydration, and malnutrition. The latter usually results in more vigorous feeding attempts and further malnutrition. If not recognized, this will eventually lead to death. In some cases, spontaneous regression of symptoms has been observed during the fourth, fifth, and sixth years in children afflicted with congenital disaccharide malabsorption. Since the small bowel surface area increases, the hydrolizing capacity is enhanced even though the total enzyme concentration per gram of small bowel tissue remains unchanged. In addition, it is also obvious that the disaccharide load offered at this age is less than that of infancy.

Diagnosis

The physician should consider the existence of disaccharide malabsorption in his differential diagnosis in every case of chronic diarrhea, especially when persistently acid pH stools occur in infants and children. In adults, an evaluation for lactose malabsorption is indicated in all cases with a history of milk intolerance and in cases of intermittent diarrhea accompanied by vague abdominal symptoms, even if the patient's history is not suggestive of milk intolerance.

There are three ways to prove disaccharide intolerance:

1. Feed the patient a large amount of the disaccharide and observe for production of symptoms.
2. Feed the patient lactose and determine whether the blood sugar can be raised by ingestion of disaccharides.
3. Assay the enzyme activity of the intestinal mucosa from a biopsy sample.

The Lactose Tolerance Test has been used widely to detect lactase deficiency.[14-17] This test is defined in terms of the blood glucose response to an oral lactose load. The reader is reminded that lactose is a disaccharide which yields glucose and galactose. Absorption of lactose is dependent on the enzymatic hydrolysis by the enzyme, lactase. The result is the appearance of glucose and galactose in the blood stream, producing a rise in blood sugar. It is generally accepted that 100 gm of lactose ingested orally will produce a 20% rise in the blood sugar concentration during a two-hour period of observation. Blood sugar levels are determined at 0, 20, 40, 90, and 120 minutes.

The final diagnostic step may then be the actual determination of disaccharidase activity in the small bowel mucosa. Such determinations are not routinely necessary for the substantiation of a "strong clinical suspicion and positive abnormal tolerance test". In instances associated with multiple disaccharidase deficiencies requiring severe limitation in dietary restriction, the ease and availability of the small intestinal mucosa for biopsy makes such a procedure advisable. Listed in Table I is a didactic classification of presently well-organized disaccharide malabsorption syndromes.

Table I: Syndromes of Disaccharide Malabsorption

I. Congenital:

1. **Congenital lactose malabsorption without lactosuria (Holzel Syndrome)**
2. **Congenital lactose malabsorption with lactosuria (Durand Syndrome)**
3. **Congenital sucrose malabsorption**
4. **Congenital sucrose-isomaltose malabsorption**

(Table I continued next page)

II. **Acquired or Secondary:**

1. **Acquired lactose malabsorption in adults**
2. **Primary malabsorption syndromes (Celiac disease, Idiopathic sprue, Tropical sprue)**
3. **Secondary malabsorption syndromes (Whipple's disease, Intestinal lymphoma, Intestinal lymphangiectasia, Abetalipoproteinemia)**
4. **Blind loop syndrome**
5. **Kwashiorkor**
6. **Acute gastroenteritis or Enterocolitis**
7. **Giardiasis**
8. **Mucoviscidoses**
9. **Regional enteritis**
10. **Extensive bowel resection**
11. **Peptic ulcer**
12. **Ulcerative colitis**
13. **Irritable colon syndrome (some cases)**
14. **Diverticulosis and diverticulitis of the colon (some cases)**

Discussion

In the past, a great deal of attention has been focused on the protein fraction of milk which was thought to act as an antigen and established the basis for an "allergic reaction". This allergic phenomenon may play a role in some children, especially those with eczema and other allergic manifestations; however, most patients who manifest bloating, cramps, and diarrhea with milk ingestion do not demonstrate atopic or other allergies.

Lactose intolerance (milk intolerance) is the only form of acquired disaccharidase deficiency found to be clinically significant in adults. In the adult patient it seems the quantity of milk taken during a single feeding is important.[18] The small amount of milk ingested in cream sauces or coffee may be tolerated without symptoms. This intolerance to larger amounts of milk is occasionally recognized by the patient who may take advantage of this intolerance and use milk therapeutically for catharsis. On occasion, milk intolerance is not appreciated by the patient until he is introduced to such dietary programs as those used in the treatment of peptic ulcer or other acid diathesis, whereupon chronic diarrhea develops, adding to the patient's discomfort. Such patients usually experience the onset of abdominal pain or cramps or both within 30 minutes after drinking milk. This is then followed by bloating, flatulence, and explosive odoriferous, watery stool within two hours.

The time sequence of onset of symptoms observed in patients ingesting lactose, who are lactase deficient, raised the suspicion that the exact pathophysiological mechanism presented in Figure III may indeed be oversimplified. Many have raised questions concerning the direct effect of lactose on the neuromuscular mechanism of the small intestine. At this time, such suspicions are purely hypothetical since no objective evidence is available to support or deter such thinking. Similarly, no evidence is available to explain the alleviation of erratic colon motility and, consequently, the symptoms seen in "the irritable colon syndrome", when milk is eliminated from the diet.[4, 18]

Certainly it appears that disaccharidase deficiency can occur as a genetically inherited trait. This observation is strengthened by familial and geographic patterns of distribution. Further, important racial differences have been demonstrated.[19, 20] In one study, 70% of the Baltimore Negro population was found to manifest lactase deficiency. This is contrasted to a 5% to 10% deficiency occurrence rate in a similar Caucasian population.[20] Similar results have been found in African populations. This marked racial difference in the incidence of lactase deficiency strongly suggests that the level of enzyme activity is genetically controlled and favors a genetic etiology for disaccharidase deficiency.

The question interposed on this genetical disposition is one of adaptation to decreased milk ingestion seen in adulthood.[20] It was recently demonstrated that patients exhibiting intolerance to maltose and sucrose could be made to tolerate these sugars when administered in progressively increasing doses. These authors not only demonstrated increased clinical tolerance but also showed increased maltase and sucrase enzyme activity in the intestinal epithelium. The latter study is the first demonstration of adaptive intestinal enzyme activity to date.

Treatment

The incidence of disaccharidase deficiency, where carefully studied, seemed of the magnitude that its presentation to the practicing physicians is likely.[3, 20-23] The physician confronted with such a problem will find himself in an area of dietetics which indeed may be uncomfortable. The following list is offered for dietary identification.

For infants:

1. Do not contain lactose but contain maltose, isomaltose, and sucrose
   - A. Sobee (Mead Johnson)
   - B. Prosobee (Mead Johnson)
   - C. Soybeans (Loma Lema) Boston style
   - D. Soybeans (Loma Lema) Tomato sauce
   - E. Ruskets (Loma Lema)
   - F. Soyagen, Carob. (Loma Lema)
   - G. Soyagen Infant Powder (Loma Lema)
   - H. Gravy Quik (Loma Lema)
   - I. Jell Quik (Loma Lema)
   - J. Soyagen, all purpose (Loma Lema)
   - K. Soyagen, liquid (Loma Lema)
   - L. Soyalac, concentrated liquid (Loma Lema)

2. Contain no lactose but contain sucrose
   A. Isomil (Bordens)
   B. Mull-soy (Bordens)
   C. Neo-Mull-soy (Bordens)
3. Contain no lactose
   A. Gerber M B F
   B. Lambase (Gerber)
4. Contains very little lactose but contains sucrose
   A. Nutramigen (Mead Johnson)
5. Contains less than 0.5% carbohydrates
   A. CHO-free Formula Base (Bordens)

For adults, since lactose intolerance is the most common adult and acquired form of disaccharidase deficiency, all one needs to exclude from the diet is milk and milk products. It is often wise to remind patients that milk products include cheese, cream sauces (salad dressing), ice cream, puddings, custards, and dessert toppings. There are presently two known lactose-free milk substitutes. They are "Dairy-Rich" and "Kool-Whip". All other powder milk products contain lactose.

REFERENCES

1. Auricchio, S., et al: Isomaltose Intolerance Causing Decreased Ability to Utilize Dietary Starch, *J Pedia* **62**:165, 1963.
2. Auricchio, S., et al: Isolated Intestinal Lactose Deficiency in the Adult, *Lancet* **2**:324, 1963.
3. Bayless, T. M., Partin, J. S., and Rosensweig, N. S.: Absence of Milk Antibodies in Adult Milk Intolerance, *JAMA* **201**:128, 1967.
4. Weijers, J. A., and Van de Kamer, J. H.: Aetiology and Diagnosis of Fermentative Diarrheas, *Acta Paedlat* **52**:329, 1963.
5. McMichael, H. B., Webb, J., and Dawson, A. M.: Lactase Deficiency in Adults: A Cause of "Functional Diarrhea", *Lancet* **1**:717-720, 1965.
6. Bayless, T. M., and Rosensweig, N. S.: A Racial Difference in Incidence of Lactase Deficiency, *JAMA* **197**:138-142, 1966.
7. Bayless, T. M., and Rosensweig, N. S.: Incidence and Implications of Lactase Deficiency and Milk Intolerance in White and Negro Populations, *The Johns Hopkins Medical Journal* **121**:54, 1967.
8. Bayless, T. M., and Huang, S.: Milk and Lactose Intolerance in Healthy Orientals, *Science* **160**:83-84, 1968.
9. Corry, D. C.: Milk in Diverticula of Colon, *Brit Med J* **1**:929, 1963.
10. Crane, R. K.: Intestinal Absorptions of Sugars, *Physiol Rev* **40**:789, 1960.
11. Cuatrecasas, P. D., Lackwood, H., and Caldwell, J. R.: Lactase Deficiency in the Adult: A Common Occurrence, *Lancet* **1**:14-18, 1965.
12. Auricchio, S., Dahlgvist, A., and Semenza, G.: Solubilization of the Human Intestinal Disaccharidases, *Biochem Biophys Acta* **73**:582, 1963.
13. Auricchio, S., et al: Disaccharidase Activities in Human Intestinal Mucosa, *Enzym Biol Clin* **3**:193, 1963.
14. Cady, A. B., et al: Lactase Deficit in Ulcerative Colitis and Regional Enteritis, (Abstract), *Gastroent* **48**:803, 1965.
15. Dahlgvist, A.: Specificity of the Human Intestinal Disaccharidases and Implications for Hereditary Disaccharide Intolerance, *J Clin Invest* **41**:463, 1962.
16. Dahlgvist, A.: Specificity of the Human Intestinal Disaccharidases and Implications for Hereditary Disaccharide Intolerance, M. H. Schon (Ed.) "Symposium on the 2nd World Congress on Gastroenterology in Munich", Karger, S., and Basel, A. G., p. 47, 1963.
17. Dahlgvist, A.: The Intestinal Disaccharide Intolerance, *Gastroent* **43**:694, 1962.
18. Dahlgvist, A., et al: Human Intestinal Disaccharidases and Hereditary Disaccharide Intolerance, The Hydrolysis of Sucrose, Isomaltose, Palatinase (isomaltulase), et al, 6 L-oligosaccharide, (isomalto-oligosaccharide), Preparation, *J Clin Invest* **42**:556, 1963.
19. Holzel, A., et al: Defective Lactose Malabsorption Causing Malnutrition in Infancy, *Lancet* **1**:1126, 1956.
20. Weser, E., and Sleisinger, M. H.: Lactosuria and Lactase Deficiency in Adult Celiac Disease, *Gastroent* **48**:571, 1965.
21. Auricchio, S., Rubino, A., and Murset, G.: Intestinal Glycosidase Activities on the Human Embryo, Foetus and Newborn, *Pediatrics* **35**:944, 1965.
22. Welsh, J. D., et al: Isolated Lactose Deficiency; Correlation of Laboratory Studies and Clinical Data, *Arch Int Med* **120**:261, 1967.
23. Rosensweig, N. S., and Herman, R. H.: Time Response of Jejunal Sucrose and Maltose Activity to a High Sucrose Diet in Normal Man, *Gastroent* **56**:500-505, 1956.



Murine Typhus:

Recent United States Surveillance and Report of an Unusual Case

The reported incidence of murine typhus (typhus fever) in the United States has been declining almost steadily for the past 15 years (Figure 1). Pratt [1] reviewed the changing picture of murine typhus in the United States as of 1956 and discussed the factors, including improved sanitation, that were most likely responsible for the decline in reported cases. Since 1956, the downward trend has continued, with 52 cases reported in 1967. As in 1956, more than half of the total cases for the United States were reported from Texas (Figure 2); none were reported from Maryland. The following case, which is the only one reported from Maryland in 1968, is presented as a reminder that murine typhus still occurs in the United States and may pose a difficult diagnostic problem, particularly when rash is not present.

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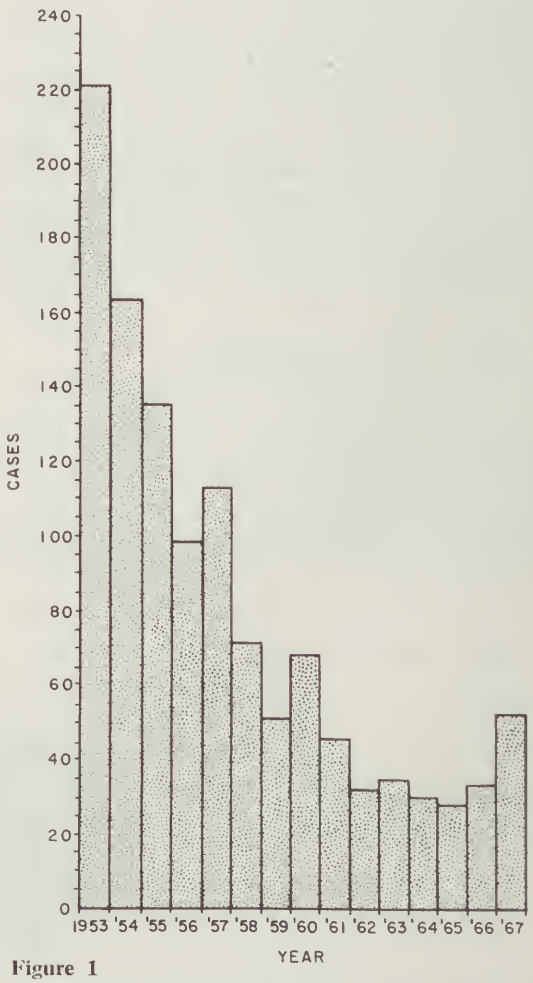


Figure 1

SOURCE OF DATA: Morbidity and Mortality Weekly Report, Annual Supplement for 1967, U.S. Department of Health, Education and Welfare, Public Health Service, National Communicable Disease Center, Atlanta, Ga. 16 (53): 1968.

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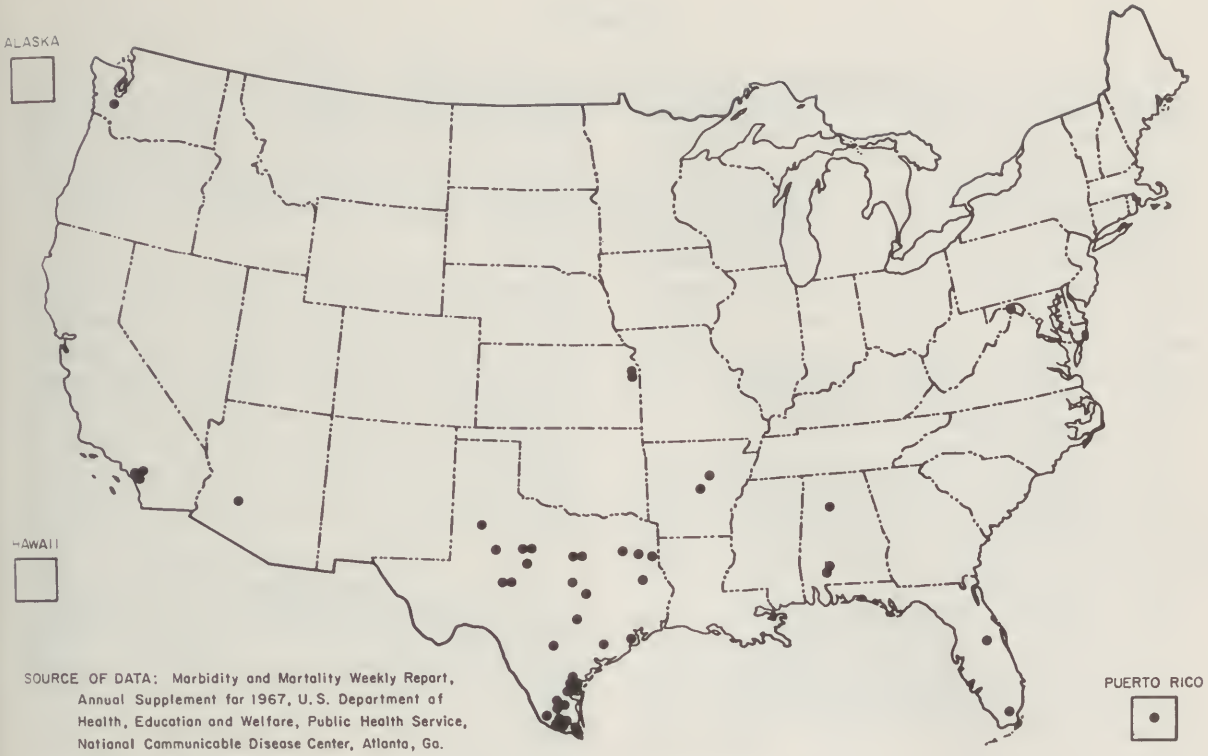


Figure 2

Case Report

The patient, a 28-year-old merchant seaman, was admitted to the Church Home and Hospital in Baltimore on August 30, 1968, with the chief complaints of fever, chills, anorexia, headache, and malaise.

He had been in good health until 11 days before admission, when en route from Mazatlan, Mexico, to Baltimore, he began having a severe headache and fever of 104°F. He arrived in Baltimore two days later and, because of the persistent headache and fever, went to a clinic. Albuminuria and flank pain were found, and his illness was diagnosed as urinary tract infection. He was treated with 2 gm of sulfisoxazole *(Gantrisin)* a day.

Seven days later, he returned to the clinic because of persistent headache. A diagnosis of an influenza-type illness was made, and aspirin was prescribed. The sulfisoxazole was stopped at this time. Three days later, due to persistent symptoms, he visited a private physician who arranged admission to the hospital.

Physical examination on admission revealed a temperature of 101.5°F, pulse rate of 88 beats per minute, blood pressure of 130/80 mm Hg and respiratory rate of 18 per minute. There was pharyngeal injection and dullness with crepitant inspiratory rales at the left lung base. The remainder of the examination was unremarkable. *There was no skin rash.*

The hematocrit level was 50%; leukocyte count was 12,300/cu mm with 28% polymorphonuclear leukocytes, 29% bands, and 43% mononuclear cells; urinalysis was normal; BUN was 14 mg % and FBS was 107 mg %. Chest X-ray showed evidence of consolidation at both lung bases, but a sputum culture revealed normal flora. Febrile agglutinins for typhoid, paratyphoid, and brucella were negative, but a Proteus X-19 titer was 1:320. A repeat Proteus X-19 titer on serum drawn four days after admission was 1:1,250. Because of the high titers, rickettsial infection was suspected, and complement fixation tests using various rickettsial antigens were performed. The results are shown in Table 1.

TABLE 1: Results of Complement Fixation Tests*

ANTIGEN	C. F. TITER 9/3/68	9/9/68
Murine Typhus	1:32	1:128
Rocky Mountain Spotted Fever	<1:8	<1:8
Q-Fever	<1:8	<1:8

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Discussion

In retrospect, this patient had many of the well described signs and symptoms of murine typhus including anorexia, malaise, headache, fever, albuminuria, and evidence of respiratory tract involvement.[2, 3] The age, race, and sex of the patient were also typical.[2] However, due to the present rarity of murine typhus in the United States and the absence of a skin rash, which is present in 64% of untreated cases,[2, 3] the correct diagnosis was not suspected until the elevated Proteus X-19 titer was noted. The diagnosis of murine typhus was confirmed by the fourfold CF antibody titer rise and the high fluorescent antibody titer.

Since the usual incubation period of murine typhus is eight to twelve days,[2] and the patient had been at sea for ten days prior to onset of symptoms, he probably contracted typhus by contact with an infected Mexican flea in Mazatlan.

The recommended treatment of murine typhus in adults is 2 to 3 gm chloramphenicol orally a day, or 1.5 to 2 gm tetracycline orally a day.[4] An adequate course of therapy, at least until the patient has been afebrile for 48 hours, is necessary lest clinical relapse occur.[5]

Based on the CF results and an indirect fluorescent antibody titer of 1:80 to murine typhus on the September 9 serum specimen, a diagnosis of murine typhus was made. The patient was treated with 2 gm of tetracycline daily for ten days, and he made an uneventful recovery.

Closer questioning of the patient revealed that his ship had left Mazatlan 21 days prior to his admission to the hospital, and that the rat population near the docks in Mazatlan was quite high.

Investigation by the U. S. Quarantine Service revealed that sanitary conditions aboard the ship were excellent with no evidence of rodent infestation, that no other members of the ship were ill with similar symptoms, and that murine typhus is endemic in Mazatlan.

Attention has recently been drawn to the risk of laboratory-acquired typhus.[6] There are data [7] to suggest that Rickettsia mooseri exists in nature in a number of wild animals including rats. Smadel [8] has predicted that naturally acquired murine typhus will continue to occur in the United States at about the present level. Therefore, physicians should remain alert to the possibility of murine typhus, especially in patients coming from areas where the disease remains endemic.

REFERENCES

1. Pratt, H. D.: The changing picture of murine typhus in the United States. *Ann N Y Acad Sci* **70:516**, 1958.
2. Stuart, B. M., and Pullen, R. I.: Endemic (murine) typhus fever: clinical observations of 180 cases. *Ann Int Med* **23:** 520, 1945.
3. Miller, E. S., and Beeson, P. B.: Murine typhus fever. *Medicine* **25:1**, 1946.
4. Weichsel, M., and Weichsel, R.: Typhus fevers, in *Current Therapy 1968,* edited by Conn, H. F., W. B. Saunders Co., Philadelphia, 1968, p 66.
5. Wisseman, C. L., et al: Antibodies and clinical relapse of murine typhus fever following early chemotherapy. *Ann Int Med* **57:**743, 1962.
6. Wright, L. J., et al: Laboratory acquired typhus fevers. *Ann Int Med* **69:**731, October, 1968.
7. Morlan, H. B., Hill, E. L., and Schubert, J. H.: Serological survey for murine typhus infection in southwest Georgia animals. *Public Health Rep* **65:**57, 1950.
8. Smadel, J. E.: Status of the rickettsioses in the United States. *Ann Int Med* **51:**421, 1959.

The Role of Computers in Electroencephalographic Analysis

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Over the past two decades, during which the computer has become an increasingly popular tool in scientific research, much work has been undertaken in the general field of computer assisted diagnosis. To this end, however, the complexities of the problem have not permitted any great advances: A breakthrough, in fact, has occurred only in one specific area—electrocardiography (EKG).

The EKG, which is an electrical correlate of the heart beat, is probably the simplest pattern used in medicine. Because of the apparent simplicity of the patterns, and because of the frequency of cardiovascular disease in the community, together with the very high volume of EKG recordings made daily, every incentive has been present to investigate methods of increasing accuracy of interpretation and speeding up processing. In spite of these incentives, final development of adequate procedures has taken over eight years. It will probably be another four or five years before routine use of computers to process EKGs becomes accepted. The methods of analysis are relatively sophisticated,[1] but permit near real-time processing with telephone linkage to a central computer. The economics of this method of EKG analysis appear to be quite competitive with human interpretation.

Two other important interpretative laboratory procedures are the X-ray and the electroencephalogram (EEG). Attempts are being made in many centers to digitize the X-ray film, normalize the outlines of the X-ray, and correlate the normalized picture with other patterns held in the computer memory. It takes little imagination to realize how difficult the process can be.

Computer analysis of the EEG has been studied very intensely in many centers throughout the world.[2] The EEG, popularly known as "brain waves", is the time-varying voltage observed between two electrodes contacting separate points of the head, typically two points of the scalp. Contact resistances between such electrodes are usually a few thousand ohms, and 20 to 100 microvolts of signal are usually obtained. The predominant frequency range is from 0 to 30 cycles per second, although some energy is present at considerably higher values. In the case of an awake subject with closed eyes there is often a well-defined peak in the frequency spectrum near ten cycles per second which disappears when the eyes are open. This frequency component is the well-known "alpha rhythm". It is particularly prominent if the electrodes are near the back of the head. Considerable variation in the character of the signal may be observed under differing experimental conditions for a given subject, and between individual subjects. For example, some individuals show almost continuous trains of alpha activity. Some exhibit frequent bursts of such activity, some infrequent bursts, and some exhibit no discernible alpha activity at all. The waves during sleep are considerably different than those during wakefulness, and there are different EEG patterns during the different stages of sleep. Furthermore, various drugs are known to interfere with the EEG pattern, and many diseased conditions of the brain show abnormal characteristics. As a result of these facts, EEG has become widely used in clinical neuro-

physiological work as an aid to the diagnosis and treatment of a variety of disorders. In this work, however, the main tool of EEG classification and interpretation is the eye of the experienced clinician observing the data directly as recorded by an ink writer. In fact, it is the clinician's function, in his evaluation of the EEG tracing, to mentally filter out the "background noise" and the artifacts of various nature and origin, and to select the elements which he considers significant and conducive to a meaningful diagnostic correlation.

In addition to all the other variables which may affect the EEG pattern and, therefore, the interpretation of the record, such as the psychologic, physiologic, and pathologic state of the subject under study, extremely important are the complex human variables intrinsic in the physician reading the tracing, such as the training, experience, alertness or fatigue, and emotional bias. When studies have been made of the degree of accuracy and consistency in the visual interpretation of the EEGs, it was found that there is a reasonably good agreement among different electroencephalographers only on the most marked abnormalities, and that there is a surprisingly wide difference of opinion in the interpretation of some of the tracings. What is even more disconcerting is that there is often disagreement between the individual observer's first interpretation and his later reclassifications of the same tracing.

In contrast to this, it is obvious that a form of automatic analysis is devoid of all the individual and day-to-day variations which are inherent in any type of human endeavor.

Because of these considerations, and even before the advent of electronic computers, there were many electroencephalographers who realized that theirs was a field greatly in need of some form of automatic analysis and, in the late thirties, attempts had already been made to design an instrument for this purpose.[3] One of the earliest approaches was to explore the EEG in terms of Fourier analysis, by which original complex and seemingly irregular waveforms, such as the EEG tracing, are decomposed in their basic, highly regular and rhythmic waveforms. A number of parameters of these basic waveforms can then be determined and measured with mathematic accuracy, and these are the voltage or amplitude of the individual waves, the frequency, or number of waves per unit of time, and the phase, or time relations of different parts of a wave as recorded simultaneously in different tracings. The determination of amplitude versus frequency ("spectral analysis") is the most popular form of EEG analysis today which can be carried out automatically with the help of commercially available, reasonably inexpensive instruments. A number of research and clinical EEG laboratories are now equipped with such instruments.

As the electronic computers become more accessible to the researcher and to the clinical investigator, it was realized that a tool was now available to achieve greater accuracy and speed in measuring the amplitude and frequency of the EEG waveforms and to perform complicated mathematical analyses which would be prohibitively time-consuming, and also liable to additional error if done by hand. It was further envisioned that the result of the automatic computation could then be printed out in any desired detail with some of the common measurements and the final interpretation reported. The results of the analysis could then be stored in computer memory along with information derived at a later time about the final diagnoses and outcome, so that probabilities could be derived for each diagnosis.

With the increase in sophistication on the part of the clinical investigators, objections to this approach became apparent. The automatic analyser available today gives only part of the information present in the original EEG tracing. During the process of automatic analysis, in fact, a large amount of information essential to the physician in his diagnostic interpretation of the record is filtered out and irretrievably lost. Lost is the information about the occurrence of transient potentials, which are essential for the diagnosis of epilepsies; lost also is all information about phase, which is often indispensable for the exact localization of lesions such as brain tumors. A further serious limitation of any automatic analyser is that it cannot recognize and compensate for the large varieties of artifacts which the experienced electroencephalographer has learned to identify and evaluate in their proper context. Muscle artifacts, sweat artifacts, movement artifacts, such as eye blinking, false signals originating from faulty electrodes and connections and from errors of the EEG machine itself or the EEG technician or both would all be accepted by the analyser and by the computer as genuine "brain waves" and treated as such.

Furthermore, if one realizes that up to 10,000,000 bits have been calculated to be necessary in describing one full EEG record in binary form, it becomes quite apparent that the handling by the computer of this information, already defaced and mutilated in the process of being analysed, is now clearly uneconomical. The futility of this approach is further emphasized if one realizes that a very large, very high speed computer could take hours to calculate frequency distributions and correlations from the amount of data contained in any single, routine EEG recording.

As an alternative to this form of computerized EEG analysis, other investigators are approaching the problem by experimenting with computer techniques for the study of patterns in the EEG ("pat-

tern recognition system").[4] By this method individual EEG patterns, believed to carry specific diagnostic connotations, are predetermined by a group of common properties which they possess. A pattern recognition system has the means to compute the values of a number of parameters from incoming data. The incoming values are then compared continually with various groups of parameters and their values which had previously been stored in the computer memory. If agreement occurs between one of the incoming groups of parameters and one of the stored groups, an instance of the pattern, corresponding to that group of parameters, is said to exist.

The main problem to be faced here is one of preselection, definition, and classification of the patterns later to be recognized by the computer. Here, once again, it is disconcerting to realize how little agreement exists among physicians on the definition and the diagnostic significance of some of the patterns observed in the EEG. While fairly uniform agreement exists in the definition of descriptive terms such as "alpha", "beta", and "delta" waves, "spike-and-wave complex", etc, the significance or the definition, or both, of other patterns such as "dysrhythmia", "14-and-6-cycles-per-second positive waves", "K-complex", etc, are still very controversial.

The systems of computer assisted EEG analysis reported above are still in the very early experimental stage. Projecting to the future the pace of current advance in this field, it seems obvious that ultimately, although the computer will become a tool used in EEG analysis, the amount of research work necessary to establish it as a necessary and economic device is likely to be measured in decades. A major accomplishment, however, has already been made, and this is to have brought to mind, to those of us in need of such reminder, that electroencephalography, in spite of its impressive achievements, is far from being an exact science and is still very much of an "art". We are still looking for the right questions to ask and often find ourselves wondering what question the EEG is an answer to. Until we have learned to better define our terms, sharpen our definitions, and to formulate more precise questions, no computer can be expected to properly substitute the man in his mysterious process of analysis called intuition.



REFERENCES

1. Caceres, C. A.: Computer analysis of medical signals. *Datamation* **11**:34-39, 1965.
2. Grass, A. M. and Gibbs, F. A.: Fourier transform of the electroencephalogram. *J Neurophysiol* **1**:521-526, 1938.
3. Brazier, M. A. B.: Computer techniques in EEG analysis. Elsevier Publ. Co., New York, 1961.
4. Farley, B. G.; et al: Computer techniques for the study of patterns in the electroencephalogram. Lincoln Laboratory Technical Report No. 165, Massachusetts Institute of Technology.

Treatment of a Highway Accident Victim

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This patient is a 21-year-old Negro man who was admitted on Christmas Day to Easton Hospital in a comatose state immediately following a highway accident. Skull films were unremarkable. He had a right femoral comminuted fracture, a right acetabular fracture, and fractures of both first ribs. Because his hematocrit dropped from 40% to 29%, he was transfused with seven units of packed cells. He was given tetanous toxoid, was started on penicillin, and underwent debridement of his open wound with insertion of a tibial pin for skeletal traction. Although consciousness slowly returned, his BUN rose from 18mg% to 122mg%, while his urine output dropped to less than 300 cc per day. Mannitol infusions proved ineffective.

On December 30, five days after his initial injury, the patient was transferred to the University of Maryland ward medical service with diagnoses of acute multiple trauma, post concussion syndrome, and acute renal failure.

Initial laboratory data revealed a normal hemaglobin, a white cell count of 19,750, serum potassium of 6.4 meq/1, and a BUN of 128mg%. By the following day, his BUN had risen to 180mg%, and the serum potassium had risen to 8.6meq/1. The patient was treated with parenteral fluid restriction, rectal administration of powdered sodium polystyrene sulfonate (*Kayexalate*), potassium exchange resin, and peritoneal dialysis through the usual temporary catheter. He was also started on a broad-spectrum bactericidal antibiotic (*Keflin*). His BUN dropped to approximately 140mg%. Subsequently, because of the expected prolonged nature of his illness, a "Barry" pericannula, semipermanent peritoneal catheter was inserted through a small laporotomy and the patient was dialyzed intermittently through this device. His BUN was maintained in the range of 140mg%. Dialysis was performed during the day, and at night the cannula was closed and dialysis was stopped so that the patient could sleep. Because of an unexplained arterial PO_2 of 39 mm of mercury, it was hypothesized that the patient might be throwing emboli to his lungs; however, this could never be substantiated.

On the morning of January 3, he experienced a transient episode of atrial fibrillation, and that evening he experienced an abrupt episode of severe respiratory distress compatible with pulmonary embolization or pulmonary edema, or both. He was intubated and started on a dehydrating 4% dialysis solution. Later that evening, a tracheostomy was performed.

On January 9, two weeks after his initial injury, he spiked a fever. A greenish exudate was noticed around the cannula site, and the cultures of the dialysate grew Pseudomonas. Subsequently, Aerobacter was grown from the blood. The patient was started on small doses of colistin. Several days later his temperature returned to normal and the cultures became negative.

By January 14, his urine output had risen to 600 cc per day. Five days later, it had increased to 2½ liters per day. Following this, the patient entered a prolonged diuretic phase and excreted as much as 8½ liters of urine per day. By January 27, 32 days after injury, his BUN was within normal limits. During this period, fluid and electrolyte losses were replaced and the patient was kept on a high carbohydrate, high fat diet.

On January 30, his tracheostomy was closed and his parenteral fluids entirely discontinued. He was transferred to the orthopedic service, and on February 20, 56 days after injury, he was placed in a spica cast and subsequently discharged.

* *The following two articles, a case presentation and discussion of the case, are from a session of Medical Grand Rounds presented during the Faculty's 1969 Annual Meeting.*

Acute Renal Failure

Acute renal failure is usually a temporary and potentially reversible suppression of renal function. Proper management demands thorough knowledge of the natural history of the disease. With such knowledge, fluids and electrolytes may be intelligently prescribed. Application of modern concepts has contributed to reduction of mortality rates, from about 90% prior to 1950 to about 30% today. This presentation will review the natural history of acute renal failure and illustrate therapeutic principles as they pertain to the presented case.

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Acute renal failure can result from prerenal, renal, or post-renal causes. Dehydration in its early stages is an example of a prerenal etiology. The renal causes are acute tubular, medullary, and cortical necrosis. Of these, tubular necrosis (formerly called lower nephron nephrosis) is the most common. Obstruction to urinary flow is post-renal.

Oliguria is defined as a urinary volume of less than 400 ml per day, but if measurements are made on a 24-hour basis only, then transient oliguria lasting a few hours may go unrecognized; patients may present in the early diuretic phase with a rising blood urea nitrogen. Hemodialysis and peritoneal dialysis are most frequently performed during the oliguric phase, but at times may be necessary in the early diuretic phase. The early and late diuretic phases have different therapeutic implications. If the patient is successfully maintained through the diuretic phase, he will enter a recovery phase which may last for six months to a year. During this time, the patient will appear well and blood urea nitrogen will be normal, but more precise tests of renal function may reveal abnormalites. At the end of the recovery phase most

patients will show normal renal function. Some patients, however, are left with documentable abnormalities of renal function, though these are usually minimal.

Most precipitating causes of acute renal failure have as the common denominator a decrease in renal blood flow and glomerular filtration rate which leads to renal ischemia. Some toxins (ie, carbon tetrachloride) directly produce renal tubular cell damage. In either case, the pathogenesis of acute tubular necrosis is obscure. Mannitol and the rapidly acting diuretics, ethacrynic acid and furosemide, are used in oliguric states in the hope that renal damage may be prevented. Their mechanism of action is again uncertain, and attributing efficacy to maintenance of renal blood flow is probably an oversimplification.

There were several possible causes of renal ischemia and acute tubular necrosis in the case presented. First, there was hemorrhage into the area of trauma in the right hip with a concomitant drop in hematocrit and probably decreased blood volume. Second, the trauma *per se* may have been associated with hypotension and renal ischemia. Third, there was the possibility of hemolysis due to a transfusion reaction from one of the several transfusions the patient had received. At one point, his urine was dark, and this raises the possibility of a fourth cause—myoglobinuria from muscle injury.

In the oliguric phase, the three main causes of death are electrolyte imbalance, chiefly hyperkalemia with cardiotoxicity; congestive heart failure; and uremia. Treatment is aimed at prevention so that the patient can be sustained until diuresis occurs. To avoid hyperkalemia, this patient was managed in the usual way with a potassium-free diet, ie, protein-free. Initially, this was limited to parenteral fluids containing glucose. On this sort of regimen it is also possible to add oral or parenteral fat supplements. Using only carbohydrates and fats, it is important to administer at least 800 calories daily for the protein sparing effect, as this will mitigate tissue breakdown and the consequent release of potassium from cells into extracellular fluid. More liberal diets may be given if more frequent dialyses are performed.

Infusion of glucose and insulin will promote transfer of potassium from extracellular to intracellular sites. This treatment is usually reserved for life-threatening cardiotoxicity and was not necessary in this case. Other electrolyte abnormalities frequently seen in prolonged oliguria—acidosis, hyponatremia, and hypocalcemia—will promote the egress of potassium from intracellular sites to extracellular fluid and will potentiate potassium's cardiotoxic effect. For this reason, severe acidosis should be prevented by giving sodium bicarbonate orally when the carbon dioxide combining power falls to about 17 or 18 mM/l or the blood pH to about 7.30. In emergencies with electrocardiographic manifestations of hyperkalemia, hypertonic sodium bicarbonate, saline, or calcium solutions may be given intravenously to reverse hyperkalemia. Because these solutions are hypertonic, they may precipitate pulmonary edema by pulling fluid into the intravascular compartment. The risk is worth taking if potassium's cardiotoxic effect is life threatening and, if reversal is achieved, cardiac function may be improved.

Some resins will exchange sodium for potassium and remove the latter ion from the gastrointestinal tract in patients who cannot excrete it in the urine. One such resin, a sodium polystyrene sulfonate (*Kayexalate*) is particularly effective. It may be given in 40 gm quantities in a retention enema once or twice daily, as used in this patient. It may also be administered orally in water, usually 10 gm two to four times daily.

Peritoneal dialysis or hemodialysis will correct all electrolyte abnormalities simultaneously. If dialysis is required for electrolyte abnormalities alone, however, it signifies failure of medical management. It should be possible through intelligent use of diet, resins, and other electrolyte manipulation to prevent hyperkalemia from threatening life.

Anabolic steroid hormones have been used to delay tissue breakdown but good documentation of their salutary effect is lacking.

In former days, the chief cause of death in oliguria was congestive heart failure. This resulted from the incorrect estimate of insensible fluid losses at about 1 L a day rather than about 500 ml under basal conditions. In planning daily replacement therapy, urinary and other losses are measured and added to estimated insensible loss. For example, if urine volume is 200 ml in 24 hours and insensible loss is estimated at 500 ml, water requirements for the day would be 700 ml. Since it is impossible to guess insensible losses precisely and since it is difficult to maintain patients on a protein-free diet in positive caloric balance, weight loss of approximately ½ lb per day is expected. If weight is maintained at a constant level, fluid retention must inevitably occur. The daily weight is the most important datum in management of patients with acute renal failure. If congestive heart failure does occur digitalis may be given, but the dosage should be decreased because of impaired excretion. In critically ill patients, dialysis may be used to remove fluid, but again, if it is necessary for this indication alone, it represents failure of medical management.

Unfortunately, the patient presented did have pulmonary edema, and a contributing factor was the inability to obtain weights. He was in traction and a scale for the entire bed was not available. He was undoubtedly overhydrated during the oliguric phase, and dialysis was necessary to reverse the process. The overhydration also changed the course of the diuretic phase.

Uremia is the last major cause of death in oliguria. Though many investigations have been performed to identify a uremic toxin or toxins, precise characterization has been difficult. Uremia is certainly more than electrolyte imbalance, since patients can have normal electrolyte values and still have all of the concomitants of the uremic syndrome such as coma, convulsions, gastrointestinal bleeding, etc. Patients may die in perfect electrolyte balance. It is certainly more than urea *per se* because patients dialyzed against a bath fluid containing urea may still improve though blood urea is unchanged. Empirically, dialysis will remove low molecular weight toxins and will help to keep patients uremia free.

In the days after 1955 when the first practical artificial kidneys were available, patients were given dialysis chiefly for hyperkalemia and usually when they had advanced uremic manifestations. As time passed, indications for dialysis changed so that now patients are treated relatively early when they have minimal symptoms and signs of uremia. Blood urea nitrogens are usually in the range of 100-150 mg/100 ml. In this fashion, patients may be kept in relatively good condition with decreased incidence of anemia, decreased tendency toward infection, and better wound healing.

The patient presented was treated with peritoneal dialysis by means of the indwelling cannula designed by Barry. This device is a flexible plastic tube with a balloon on one end. The balloon is surgically placed in the peritoneal cavity and pulled up against the peritoneal membrane just inside the abdominal wall. A doughnut-shaped disk is slipped down around the tubing to the skin and is held in place by a metal clip. *In situ,* the balloon inside and the disk outside prevent leakage. Since the balloon is also doughnut-shaped with a hole in the middle, the usual dialysis catheter may be introduced through the tubing into the peritoneal cavity. When dialysis is finished, the catheter is removed and replaced by an obturator. As in the presented patient, it is possible to perform frequent dialyses during the day and to let the patient sleep at night. In this way, a relatively uremia-free state may be maintained. There was, however, a complication sometimes associated with the device—infection around the cannula site and peritonitis. This was managed with antibiotics, and it was possible to continue the patient on the intermittent dialysis regimen. At the present time, the chief cause of death in acute renal failure is infection. It is unfortunate that devices such as these which can potentially introduce infection are necessary, but their role in obviation of advanced uremia is secure.

If the patient survives the oliguric phase, he will enter a diuretic phase which can be divided into early and late parts. From the point of view of management, renal function remains poor early and therapy is unchanged. Since concentrating ability is decreased, clinical and chemical deterioration can proceed until volume increases sufficiently. It usually requires between 1,500 and 2,500 ml of urinary volume daily before the blood urea nitrogen will begin to fall.

Once urinary volumes are above 2,500 ml, fluid and electrolyte losses may be a problem. It is helpful to measure urinary electrolyte concentrations in planning replacement. For example, if 5 L of urine are excreted containing 70 mEq/L of sodium and this is likewise replaced, the patient will retain a normal plasma sodium. If the patient is replaced with 5 L of fluid containing less sodium, then hyponatremia will ensue. If the patient is replaced with the appropriate amount of fluid but excess sodium, there will be hypernatremia. It is possible to cause dehydration or overhydration and to give deficient or excess electrolyte replacement during this time when excretion is relatively fixed. It is up to the physician to measure losses and to attempt to replace them precisely. Chronic renal disease may be considered in the same light, ie, as a prolonged diuretic phase. As the disease progresses, the kidneys' normal ability to vary output dependent upon intake is gradually lost and the physician must measure losses and be guided in replacement accordingly.

The patient presented was undoubtedly overhydrated during the oliguric phase and his diuresis was unusually large, amounting to 8½ L a day. In the past, patients excreted up to 12 L daily during the late diuretic phase, but today, with more enlightened fluid restriction guided by daily weights, most patients excrete less than 4 L a day.

The possible pulmonary infarctions in the illustrative case are an interesting phenomenon in acute renal failure. This has been described previously in many patients, but usually adequate documentation of pulmonary embolization is lacking. This patient may represent another example of the clinical picture of pulmonary infarction in this setting without the actual occurrence of such infarction.

In summary, most precipitating causes of acute tubular necrosis are associated with decreased glomerular filtration. Death from a precipitating cause, such as the accident this patient had, may occur in the first few days. It usually takes between five and ten days of oliguria before signs and symptoms of uremia and other complications—electrolyte imbalance and overhydration—appear. Management consists of attempts to maintain salt and water balance, usually by fluid restriction, diet, resins, and dialysis. In the diuretic phase, salt and water losses are a problem and these are again managed with appropriate salt and water prescription. The patient presented was young and healthy at the time of the accident and showed remarkable recuperative powers. These factors undoubtedly contributed to his recovery.

your medical faculty at work

by John Sargeant
Executive Director

The Executive Committee met on Thursday, May 7, 1970, and took the following actions:

1. Authorized its regular financial assistance to (a) the Maryland League for Nursing, and (b) the Student American Medical Association Chapter at The Johns Hopkins University School of Medicine;
2. Declined to grant legal defense to two physicians because of late payment of dues even though they had legitimate reasons. The Committee indicated it did not have the authority to supersede the Bylaws provision in this regard;
3. Approved the President's suggestion to appoint an ad hoc committee to investigate the MEDIC network. The Chairman of the Committee on Postgraduate Education, Preventive Medicine and Public Health would be asked to chair the committee, and its membership would be composed of proponents and opponents of the network, equally represented;
4. Authorized the Faculty office to mail out organ donation forms to potential donors upon their request;
5. Renominated Marcus W. Moore, MD, Baltimore, to serve another term on the Advisory Council on Hospital Construction;
6. Declined to submit a nominee for possible appointment to the Baltimore City Jail Board, since city officials did not request a nomination. The Committee indicated that it would be willing to make a nomination should the Mayor ask for such a recommendation;
7. Directed the Library Committee to continue to study the question of charging for Library-prepared bibliographies, as instructed by the Council in 1956 and 1963;
8. Authorized attendance of the Executive Director at a meeting on Peer Review Activities by Foundations for Medical Care;
9. Authorized appointment of Stanley M. Rosen, MD, Baltimore, to serve as Faculty representative on the Renal Disease Committee of the Regional Medical Program to succeed William G. Esmond, MD, Baltimore, whose term has expired. Dr. Esmond will continue to serve as Chairman of the Faculty's Ad Hoc Committee on Renal Dialysis and Transplantation;
10. Heard a recommendation from the Medical Economics Committee that the Faculty request Blue Shield to attempt to increase fee schedules in Blue Shield Plans A and B. It also heard that this was under consideration by Blue Shield and decided to request information on the current status of this proposal;
11. Accepted a report from the Medical Economics Committee regarding proposed arbitration, or fact-finding panels in connection with malpractice actions. The report is as follows:

Secretary of Health Proposal

This proposal is similar to programs that have been adopted throughout the country. Some have been successful, particularly those in small communities where there is a more personal relationship between the physicians and attorneys and where the patient is well-known by the entire community.

In larger areas, such as Philadelphia and New Jersey, they have not been successful. Legal counsel has indicated that this will not result in any diminution of malpractice actions but may well increase them.

There is no assurance that the patient will not seek the services of another attorney and institute suit, even if the panel agrees that no cause exists for such a suit. Data and information made available to the attorney for the plaintiff can also be used against the physician, which is undesirable especially in the adversary situation that exists today.

There is also some question as to whether the Professional Liability Insurers would agree to such arbitration, and the company now insuring physicians in Maryland, in a cooperative arrangement with the Faculty, might well agree to discontinue such arrangement. If this occurred it would make it extremely difficult for physicians to obtain coverage, inasmuch as many companies are declining to write this type of insurance.

The committee agreed to recommend that this proposal not be accepted as a desirable one because of the many problems involved, not the least of which is its questionable acceptance by the Bar Association and particularly the Plaintiff's Bar Association.

Legal Counsel Proposal

The committee then considered the proposal of Mr. John King, legal counsel, which would establish an arbitration panel composed of one physician selected by the patient and one selected by the attending physician. These two would select an attorney and if one could not be agreed on, the President of the State Bar Association would serve or designate an attorney to serve. This latter person would act as chairman.

The patient would have to sign an arbitration agreement prior to receiving medical care so as to make such arbitration binding under the law.

The committee agreed unanimously that this type of proposal should be rejected. Not only would it result in more cases, in their opinion, but it would destroy the confidence the patient has in his physician and it could lead to further deterioration of the traditional physician-patient relationship.

The committee was also of the opinion that this might be pursued for those "service" patients where no such physician-patient relationship existed. This should be discussed with the Hospital Council and the committee recommends that the Executive Committee pursue this.

Workmen's Compensation Type Proposal

This idea was suggested as an alternative to the above proposals. All physicians would pay into a common pool with premiums based on costs, etc. Set sums would be established as the cost of loss incurred in each situation and a commission would establish whether there was cause.

More details would have to be considered and it was proposed that this suggestion be pursued at the next committee meeting when representatives of the St. Paul Companies will be present.

The Council met on Tuesday, May 12, 1970, and took the following actions:

1. Received the report of the Policy and Planning Committee regarding recommendations contained in the Report of the AMA's Commitee on Long Range Planning:

Recommendation Number 1:

(a) That the AMA adopt the following as a statement of the primary purpose and responsibility of the Association and the medical profession:

> "To endeavor, by all appropriate means, to make health services of high quality available to all individuals, in a dignified and acceptable manner, regardless of their social class, ethnic origin, ability to pay for services, or the source of the payment."

(b) The adoption of the following as a corollary or, rewritten, as a separate policy statement:

> "The American Medical Association has the duty to guide and assist the medical profession in the attainment of this objective."

Recommendation Number 2:

That, while the AMA must be prepared to accept some circumscription of the traditional privileges and freedoms of physicians, the following policy be adopted:

> "That the American Medical Association recognize the need for new and improved methods of delivering health services, that it encourage and participate in efforts to develop them, and
>
> "That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are maximum professional independence, a multiplicity of practice options, and freedom of choice for both physicians and patients."

Recommendation Number 3:

That the AMA officially adopt the following definition of health:

> "Health is a state of complete physical and mental well-being and not merely the absence of disease or infirmity."

Recommendation Number 4:

The Policy and Planning Committee offers the following substitute recommendation which the Faculty's Delegates to the AMA House should support in lieu of the recommendation of the AMA Committee:

> That AMA adopt an active role and take the initiative in developing plans and programs for the medical aspects of health care; that the AMA show a continuing interest and cooperate actively in the nonmedical components of health services; and that it encourage and assist state and county medical societies to do the same at their respective levels.

(Continued next page)

Recommendation Number 5:

(a) That an appropriate committee or division of the Association secure data from all the state medical societies on the adequacy of health services and the manner in which they are being provided in their rural and underprivileged areas, and the practice mechanisms, if any, that are being considered or developed to correct existing deficiencies. Based on this information, the same committee should devise delivery systems consonant with the Association's principles and incentives for physicians to settle in medically deprived localities.

(b) That the Association, in conjunction with state and county medical societies, establish a service of consultation and assistance for such physicians to facilitate the planning and financing of their projects.

(c) That, in those instances in which physicians cannot be found to develop health care facilities with the capability of providing needed services, the AMA urge, encourage, and assist the state and local medical societies to do so on an operational basis.

(d) That the Association *study the possibility of establishing a corporation for this purpose, with subsidiary corporations at state and local levels. All such corporations should be legally empowered to receive payments for services rendered and would apply surplus income over expenditures to activities designed to improve health care in their areas, both quantitatively and qualitatively.

(e) That the AMA and the constituent and component medical societies seek the active involvement of medical centers and voluntary hospitals in health service projects for the medically underprivileged.

* This word "study" is extremely important, inasmuch as the long-standing policy of the AMA and the profession has been one of opposition to the Corporate Practice of Medicine.

The Policy and Planning Committee felt it important that emphasis be placed on the word study. With this cautionary comment, the committee recommends support of this recommendation by the Faculty's Delegates to the AMA.

Recommendation Number 6:

(a) That the AMA, through its Council on Health Manpower, in conjunction with other professional, educational, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

(b) That the Association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are *not* due merely to an insufficient number of health professionals across-the-board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

(c) That the Association publicize the reasons for the maldistribution, as outlined in this section and amplified in Dr. Budd's minority report and stress that the *voluntary* correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

Recommendation Number 7:

(a) That an appropriate committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their practice, and supervision of their services by qualified physicians.

(b) That the AMA reaffirm the principle that the basic responsibility for the care and welfare of patients lies with their physicians of record and that that responsibility cannot and should not be delegated.

(c) That the Association's Law Division assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of physicians' assistants.

Recommendation Number 8:

(a) That an appropriate committee of the AMA be charged with the task of establishing the basic criteria which any proposed system of delivery of health services or mechanism for payment must satisfy to be acceptable.

(b) That the Association, in all public statements, emphasize the concept that local conditions may necessitate different systems of delivering medical care for different population groups.

(c) That the state and local medical societies be encouraged and assisted in devising and proposing practice expedients suited to their localities and their problems.

(d) That the Association, in conjunction with the state and county medical societies, establish a consultation and assistance service for physicians or groups of physicians who wish to develop organizations or programs for the rendering of health services.

(e) That the AMA endeavor to be informed of the pilot projects that are proposed by other sources and that it request the department of HEW to discuss those projects with the Association before they are put into effect.

(f) That the Association seek to ensure that the value judgments made by the Department of HEW on plans, programs, pilot projects and payment mechanisms are firmly based on the criteria and standards the AMA has developed for that purpose.

Recommendation Number 9:

(a) Urge state medical associations to undertake various studies, including surveys of medical care costs.

(b) Develop a uniform methodology for conducting such studies to the end that the data from the various states and localities be comparable.

(c) Serve as a clearing house for the material thus obtained and, after analysis, redistribute the data to the state medical associations with suggestions and conclusions.

(d) Urge the state medical associations to designate negotiators who are qualified to deal energetically with government agencies on all matters pertaining to tax-supported programs. Such individuals or groups should be formally appointed and the government jurisdiction involved should be notified that all negotiations will be conducted by them.

Recommendation Number 10:

(a) That the AMA urge state and county medical societies to assume the functions of monitoring fees and containing the costs of health care.

(b) That the Association, in cooperation with the constituent societies, determine what powers the state and local societies require to serve these functions and how those powers can be best obtained.

Recommendation Number 11:

(a) Endorse the principle of voluntary, life-long postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

(b) Through the state medical societies, investigate the current status of in-hospital audit methods and make a similar investigation of the state of development of the evaluation of office services.

(c) Encourage and assist the state medical societies and state departments of health and welfare to develop uniform and effective method of audit for both office and in-hospital services, based on electronic data processing, to the maximum possible extent.

(d) Request the Law Division to clarify the extent to which a physician's responsibility for the privacy of his patients' records will permit him to cooperate in an audit of his office practice.

Recommendation Number 12:

(a) That the AMA encourage and assist all state medical associations to devise programs for voluntary postgraduate study designed to maintain medical education at an optimum level and to be least disruptive to the provision of medical services.

(b) That the Association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

(c) That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for medical practice and restoring the licensing authority to the proper agency.

Recommendation Number 13:

(a) That the Association secure data from state and county medical societies on problems in physician-hospital relationships in their areas and the measures, if any, that are being taken to solve them.

(b) That, on the basis of these data, the Association identify the basic principles that apply to staff-hospital relationships and encourage state and county medical societies to do the same.

(c) That the Association and each state and county medical society request its counterpart in the hospital association structure to assist in developing guidelines and urge their member associations and hospitals to implement them.

Recommendation Number 14:

(a) That the Association, through its current liaison with the NABSP, seek to obtain continuous and current information on the Medicare Program; that it secure data on the development of additional benefits, new fields of coverage, and minimum standards of benefits in voluntary plans; and that, through the NABSP, it stimulate the Blue Shield Plans to greater efforts in upgrading their programs.

(b) That a similar liaison committee be developed in conjunction with the Blue Cross National Association for similar purposes.

(c) That the AMA advise state and county medical societies to take similar action at their respective levels and to review their representation on the boards of directors of their local Blue Plans to be sure that their representatives are individuals who are currently active in society affairs and familiar with society policy.

(Continued next page)

(d) That the Association seek a formal and direct channel of communication with the Department of Health, Education and Welfare, with the object of developing its own capacity for modifying existing and new programs when such modification is indicated, rather than relying solely on the NABSP for this purpose.

Recommendation Number 15:

(a) An appropriate committee or division of the Association gather information from the state medical societies on the availability of physicians, ancillary personnel, hospital beds in all categories, laboratories, public health nurses, social service workers, and all other types of health professionals.

(b) The Association promulgate a "Health Bill of Rights" to identify the services that comprise comprehensive health care.

(c) On the basis of the data obtained from the state medical societies, the Association establish minimum standards for health care and a system of priorities for the provision of services beyond those minima, thus creating both an immediate and a long range schedule for their attainment.

(d) The Bill of Rights, the data and the standards and priorities receive wide publicity.

Recommendation Number 16:

(a) That the Association request the state medical societies to submit information on the status of comprehensive areawide planning in their states and the problems that are being encountered.

(b) That this information be analyzed, summarized, and redistributed to the state societies, together with the suggestions made in the preceding paragraphs and a resume, prepared by the Law Division, of the provisions in the law that are pertinent to those suggestions.

(c) That the implementation of comprehensive areawide health planning be reviewed periodically and that the state and county medical societies be advised of the problems and pitfalls in this difficult but important area of endeavor.

Recommendation Number 17:

That the present structure of the association be retained and that it be strengthened by improvements and modifications in its function.

Recommendation Number 18:

(a) That an immediate survey be conducted of the state medical societies and, through them, of the component county medical societies to determine what arrangements they have made, if any, for the regular collection of data on the socioeconomics of health care.

(b) That, on the basis of the information received, the AMA develop tables of organization for research divisions at the state levels and methods of participation for county societies that are in keeping with their resources. The planning should be developed along lines that are compatible with the concept of a tight federation of societies and are least disruptive to research divisions that are already in existence.

(c) That the association hold a series of working meetings with state and county medical society executives, individually or in groups, to further refine the organizational patterns and procedures that will best serve them in this collective endeavor.

Recommendation Number 19:

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

Recommendation Number 20:

That the AMA sponsor, promote the formation of, and participate in, a "National Academy of the Health Professions for Research and Policy."

2. Decided that the June 1970 Council meeting should be held in the Faculty building;

3. Briefly discussed the Abortion Repeal bill and decided on no further action.

The Executive Committee met on Thursday, May 28, 1970, and took the following actions:

1. Heard that the Court of Appeals Committee on Rules and Practices and Procedures of the Court had declined to establish a rule requiring posting a bond of $500 by plaintiffs in malpractice suits;

2. Heard that the Court of Appeals has denied a writ of certiorari in the case of Conley vs State of Maryland. The Faculty had filed an Amicus Curiae brief which involved the conviction of an addict on the basis of information provided a physician during treatment. The conviction was for "possession of heroin" based on evidence of ingestion. Legislation has since been enacted and signed into law by the Governor which prohibits use of such data in civil or criminal proceedings;

3. Discussed "areas of mutual concern" with AFL/CIO representatives, and agreed to recommend that the President be empowered by the Council to appoint an ad hoc committee to act as liaison with a similar group from the union;

4. Declined to file an Amicus Curiae brief in a court case to test the constitutionality of the current abortion statutes;

5. Determined not to reprint the Annual Reports being published in the June issue of the *Maryland State Medical Journal,* thus saving about $400. All delegates, alternates, and component officers will be advised to retain this issue of the Journal and take it with them to the Semiannual Session in Hershey on September 11, 1970;

6. Authorized attendance of a Faculty representative at the AMA-sponsored National Congress on Health Manpower in Chicago on October 22-24, 1970;

7. Authorized the Program and Arrangements Committee to change the Annual Meeting dates for 1971 to coincide with available dates of suitable facilities;

8. Authorized appointment of a Faculty representative to the Hearing and Vision Early Screening Board;

9. Authorized sponsorship of a Symposium on Emergency Room Care in cooperation with the Emergency Room Physicians organization;

10. Rereferred to the Council a proposed participation agreement that the State Department of Health is planning to require all providers of services to Medicaid patients to sign.



Medical News

(Continued from page 37)

Luis Miguel Cuza, MD, of North East, and **Joseph G. Lanzi, MD,** of Elkton, have been reelected to active membership in the American Academy of General Practice.

Reelection signifies that the physician has successfully completed 150 hours of accredited postgraduate medical study in the last three years. Members become eligible for reelection at the end of the third year following their election to membership.

* * *

J. David Nagel, MD, of Towson, was recently certified in internal medicine by the American Board of Internal Medicine.

Dr. Nagel is a member of the Baltimore City Medical Society.

* * *

Antonio K. Olmedo, MD, of Towson, recently became a Fellow of the American College of Anesthesiologists.

* * *

A film highlighting the early detection of hearing disorders and prompt treatment to prevent further hearing loss, "Deafness in Children", is now available from the State Department of Health and Mental Hygiene.

Filmed at The Johns Hopkins Hearing and Speech Center, the 25-minute film follows a diagnostic study of Barry, a two-year-old with speech and hearing problems.

Suggested for parent education groups and for general audiences from high school through adult level, the film may be borrowed without charge from the Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore, phone 383-3010, extension 8516. Time should be allowed to preview the film and to arrange for a discussion leader.

* * *

Increasingly stringent federal regulations on motor vehicle emissions will be imposed in accordance with a timetable announced by the Department of Health, Education and Welfare.

Beginning with the 1975 model year, proposed new standards will sharply lower the limits on exhaust emissions of carbon monoxide and hydrocarbons from the levels in effect on 1970 models. In addition, the new standards will set limits for the first time on exhaust emissions of nitrogen oxides, to begin with the 1973 model cars, and will set limits for the first time on exhaust emissions of particulates, beginning with the 1975 model year.

* * *

Wisconsin has banned the sale and use of DDT for any purpose other than control of epidemic diseases affecting humans, plants, or animals which are spread by insects and which cannot be effectively controlled by other pesticides. Special state board approval is needed for any use of DDT.

* * *

Air Quality criteria for carbon monoxide, photochemical oxidant, and hydrocarbons have been issued by the National Air Pollution Control Administration, together with reports on recommended control techniques for the sources of these pollutants. Résumés of the criteria may be obtained from NAPCA, 5600 Fishers Lane, Rockville, Md., 20852.

Under the provisions of the Air Quality Act, states must hold hearings on standards for these pollutants and then adopt plans for implementation and enforcement.

* * *

A marked increase in syphilis cases in the United States was reported by the National Communicable Disease Center for the first four months of this year.

The infectious disease jumped as much as 50% or more in some areas while the nation as a whole experienced an increase to 6,861 cases from 6,203 for the same four-month period last year. One of the biggest increases was noted in New York city where 1,241 cases were reported as compared with 863 for the same period last year.

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JEAN R. STIFLER, MD, ACTING COMMISSIONER

Maryland State department of health

Maryland's Poison Information Center

During 1969, 5,630 cases of poison ingestion were recorded by the Maryland Poison Information Center, a project of the State Health Department at Baltimore City Hospitals.

Approximately 3,000 of these cases were reported directly to the center, and the others were reported through poison control centers at eight Maryland hospitals: Johns Hopkins, Sinai, and University of Maryland hospitals in Baltimore city; Sacred Heart Hospital in Allegany County; Holy Cross and Suburban hospitals in Montgomery County; Memorial Hospital in Talbot County; and Washington County Hospital.

Although there is an increase over the 1968 total of 5,141, it does not necessarily mean that more people suffered from poisoning. Mary S. Furth, MD, director of the center, believes that the higher figure for 1969 may reflect an increase in reporting as the center's services have become more widely known.

Medicines were ingested more frequently than any other potentially poisonous product during the past year. There were 380 poisonings from aspirin, 198 from tranquilizers and barbiturates, 630 from other internal medicines, and 173 from external medicines.

Pesticides and miscellaneous household products accounted for 723 of the poisoning cases recorded.

In 110 cases, suicide was attempted; 72 were poisonings with undetermined intent; and 2,104 were known to be accidental.

Young children suffered the largest number of poisonings—1,570 in the one to four age group, and 101 in the five to eleven age bracket. Eighty-nine of the children in the one to four group were repeaters, and 8% of those in the pediatric age group had suffered from poison ingestion more than once. It is predictable that such children will experience more ingestions within the next six months to one year, and there appears to be a need for evaluation of the parent-child relationship in such cases in order to give parents the necessary support and assistance in developing environmental safeguards.

Among persons 12 years and older, there was an 80% increase over 1968 in all kinds of internal medicines poisonously ingested. Tranquilizers showed a 40% menace, aspirin 9%, and miscellaneous medicines 31%.

These ingestions are considered self-poisonings and generally are not accidental; many of them were classified as suicide attempts. Sixty-two percent of those among patients 12 years and older were of a questionable nature and were not assumed to be accidental. Usually persons in this age group ingest toxic amounts and require hospitalization.

In the counties of Maryland, deaths from poison ingestion totaled 81 during 1969.* Of these, 66 were classified as suicides, and 15 as accidental deaths. Except for two children under two years of age, all of the deaths were among persons above 16 years.

There were 100 poisoning deaths reported in Baltimore city.** Fifty-eight were attributed to narcotics, 37 to drugs, and the others to miscellaneous substances. Twenty-six of the deaths in the city were suicides.

Barbiturate poisoning caused 23% of the deaths from poisoning in Baltimore city, and 33% of those in the counties.

Ingestion of poisonous amounts of medicine constitutes a severe threat to life, especially in the case of the barbiturates. Use of these for deliberate self-poisoning, in some cases resulting in death, warrants medical reevaluation of the need to prescribe them so frequently. Also, there is a need for psychiatric evaluation and support of patients in order to curb abuse of these medications.

** Statistics do not include narcotic deaths.*

*** Statistics do not include carbon monoxide deaths.*

Information accumulated by the Maryland Poison Information Center is useful in providing some idea of the scope and type of poisonings which are occurring in the state, and has proven to be of practical value in educational and preventive efforts. It is important to note, however, that these statistics cannot be regarded as representative of the total problem in the state, since many areas are not reporting poison incidences to the center.

The Poison Information Center is in operation 24 hours daily, seven days a week. Dr. Furth and her staff give instructions for emergency first aid in poisoning cases until medical assistance is available. No treatment is given at the center, but emergency cases are referred to hospitals for care. In 1969, 457 individuals were referred to Baltimore City Hospitals.

Any physician in the state may request information on toxic products and their antidotes.*** Telephone requests for information during 1969 included 592 from physicians and other medical personnel, and 2,091 from nonmedical sources.

The center conducts follow-up on certain poisoning incidences, and also conducts educational efforts for health professionals, parents, and various organizations.

* * *

Smallpox Vaccination Complications, Maryland, 1968

During 1968, the Division of Communicable Diseases of the Maryland State Health Department, in conjunction with members of the Department of Pediatrics of The Johns Hopkins Hospital and the Smallpox Eradication Program of the National Communicable Disease Center, conducted a semiprospective study to determine the number and types of complications associated with smallpox vaccination in Maryland. Seventy-eight percent of 3,800 Maryland physicians returned a mailed questionnaire requesting reports of vaccination complications. A total of 105 patients with complications following smallpox vaccination were reported.

The most frequent complications were accidental infections (25 cases), and erythema maltiforme reactions (27 cases). Other commonly noted complications were severe local reactions (20 cases), generalized vaccinia (16 cases), and eczema vaccinatum (9 cases). Eighty-one of the patients were primary vaccinees, eleven were revaccinees, and six were contacts of recent vaccinees. The majority of the patients were primary vaccinees in the one to four years age range. There were no deaths reported, and although most complications were mild, 17 patients did require hospitalization.

Precise data on the number of smallpox vaccinations performed in Maryland during 1968 are not available. However, proportional figures for Maryland can be derived from the United States Immunization Survey 1967-1968 (page 24, DHEW, PHS, Health Services and Mental Health Administration, National Communicable Disease Center, Atlanta, Georgia, December, 1968). Using these data, the approximate rates of complications were 1 out of 1,000 primary vaccinations and 1 out of 15,000 revaccinations.

1. The optimal time for primary smallpox vaccination is between the first and second birthdays.

2. Individuals with eczema and other forms of chronic dermatitis in any stage of activity should not be vaccinated and should not be exposed to recently vaccinated individuals. Persons with poison ivy, impetigo, or other more acute skin lesions should not be vaccinated until the skin has healed. Persons who might expose household contacts with eczema or other chronic dermatologic illnesses should not be vaccinated unless adequate separation between the vaccinee and his contact can be maintained until the scab falls off.

3. Pregnant women should not be vaccinated.

4. Persons with leukemia, lymphoma, blood dyscrasias and other altered immunologic states or on immunosuppressive therapy such as steroids, antimetabolites, and ionizing radiation should not be vaccinated.

If vaccination is essential in the above individuals because of potential exposure, or recent exposure, to smallpox, or if one of the above individuals has been vaccinated through error, expert consultation should be sought.

For a more detailed review see *The Johns Hopkins Medical Journal*, **126:** No. 3, March, 1970, page 160.

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Metabolic Changes Associated with the Cessation of Cigarette Smoking

Two-part study of seven volunteers, first while still smoking and again a month after they had stopped, revealed metabolic changes which partially accounted for undesirable weight gained by six participants.

Much effort has gone into convincing cigarette smokers that they should stop smoking since cessation has been shown to reverse some adverse effects due to smoking. Frequently, however, persons who stop smoking gain weight in the succeeding weeks. This undesirable weight gain is often attributed to increased eating due to some sort of psychological compensatory reaction. However, the cause is actually unknown. The present study of seven volunteer smoking scientists was undertaken to determine if the cessation of smoking was associated with any gross metabolic changes that could account, in part at least, for weight gain.

Each subject underwent two batteries of tests, the first one while still smoking and the other after he had stopped smoking for a month. Both test series included a thorough physical examination, blood chemistry analysis, and pulmonary function tests.

For the first test the volunteers abstained from smoking, as well as eating and drinking, for at least 12 hours. The whole test procedure was administered in the supine position after a brief half-hour rest period.

Respiration rates were recorded during the initial phase of the examination while inspired and expired samples were collected for gas analysis and gas volume determinations. Temperature and blood pressure were taken by routine methods, as was a six-lead electrocardiogram using the limb leads.

Venous blood samples were collected in tubes without anticoagulant for serum cholesterol, calcium, and protein-bound iodine (PBI) determinations. Anticoagulated blood samples from the fasting participants were also used for blood glucose, hemoglobin, and hematocrit measurements. Then each volunteer was given 150 ml of a 50% glucose solution in ice. Another venous blood sample was drawn for a postprandial glucose determination a half hour later. Finally, subjects were permitted to stand for height and weight measurements.

Blood glucose determinations were derived from the ferricyanide reduction method adapted for the autoanalyzer; PBI analysis from the wet ash and ceric ammonium sulfate-arsenous acid method, also adapted for the autoanalyzer. Cholesterols were derived from the Pauvionsky method.

Hemoglobin concentration was determined spectrophotometrically, using Drabkin's reagent. The hematocrit was read in microcapillary tubes. Serum calcium levels were determined by atomic absorption spectroscopy.

Analysis of data was made in paired comparison, with each subject serving as his own control.

Histories revealed that the seven participants had smoked an average of 12.7 years and consumed an average of 1.4 packages of cigarettes daily. Only two had developed a chronic cough.

Average age for the seven was 31.4 years: the average height, 178.7 cm (70.21 inches).

Change Between Test Periods

Significant changes had occurred between the two test periods. The average weight rose from 83.29 kg (188.3 lb) to 87.33 kg (194.7 lb). The average body surface area, as measured against the nomogram of DuBois, rose from 2.03 meters squared to 2.05 meters squared. This increase was due to the increase in body weight.

The average blood pressure rose 113/73 mm Hg to 117/73; the average heart rate on ECG dropped

Stanley C. Glauser, MD, PhD, Elinor M. Glauser, MD, Marcus M. Reidenberg, MD, Ben F. Rusy, MD, and Ronald J. Tallarda, PhD, *Archives of Environmental Health* (Vol. 20) March 1970.

from 60 beats to 57 beats per minute. The hematocrit remained constant (44.2 per 100 ml); so did blood glucose of fasting participants at an average of 87 mg/100 ml. However, the average 30-minute postprandial blood glucose level dropped from an average of 137 mg/100 ml before to 123 mg/100 ml after they quit smoking. The PBI dropped from 5.1 μg/100 ml to 4.6 μg/100 ml. The average hemoglobin rose from 13.3 gm/100 ml to 14.0 gm/100 ml, while the serum calcium dropped from 10.2 mg/100 ml to 9.7 mg/100 ml.

The average oxygen consumption dropped from 283 ml/min to 260 ml/min. The average carbon dioxide production dropped from 213 ml/min to 210 ml/min.

The respiratory quotient was calculated for each individual by dividing carbon dioxide production by oxygen consumption. The average respiratory quotient rose from 0.75 to 0.81. The average respiratory rate rose from nine breaths per minute to ten breaths per minute. Electrocardiographic patterns remained constant. Temperature remained constant at an average of 36.4°C (97.6°F).

Six of the seven volunteers gained weight during the month between tests. The seventh, who maintained his weight, reported a marked increase in activity.

Some of the other significant changes from the first test period to the second were the increases in body surface area and respiratory quotient, and decreases in PBI and serum calcium levels.

Especially significant was the decreased hyperglycemic response of the participants to a glucose meal after cessation of smoking while the blood glucose level, when they were still fasting, remained constant. The decreased heart rate was small, but statistically significant.

Metabolic Change

All these changes suggest a metabolic change. Such a change could cause a decreased basal oxygen consumption. Such a decrease was noted in six of the seven participants in the present study. With no change in caloric intake or physical activity, this metabolic change would cause a weight gain.

Other known changes produced by smoking include an increased heart rate, blockage of normal metabolism of tryptophan, induction of benzpyrene hydroxylase in placental tissue, and decrease in carbonic anhydrase in fetuses. Nicotine has been shown to cause an increase in tryptophan pyrrolase, and in the rate of metabolism of ethylmorphine, norcodeine, and aniline.

The metabolic changes following the cessation of smoking, described in this study, may be one of the reasons for the weight gain observed. The authors suggest that weight gain may not be due solely to increased caloric intake without parallel physical activity, as is generally thought.

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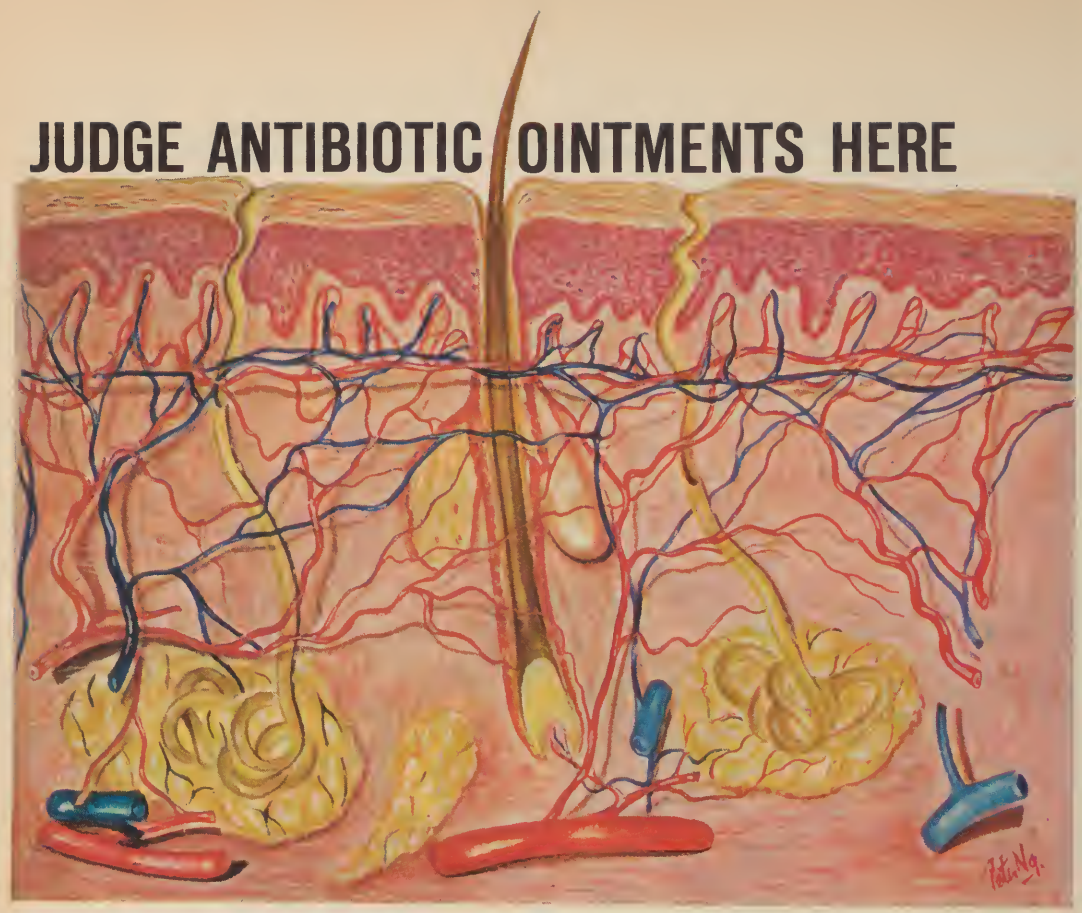
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1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

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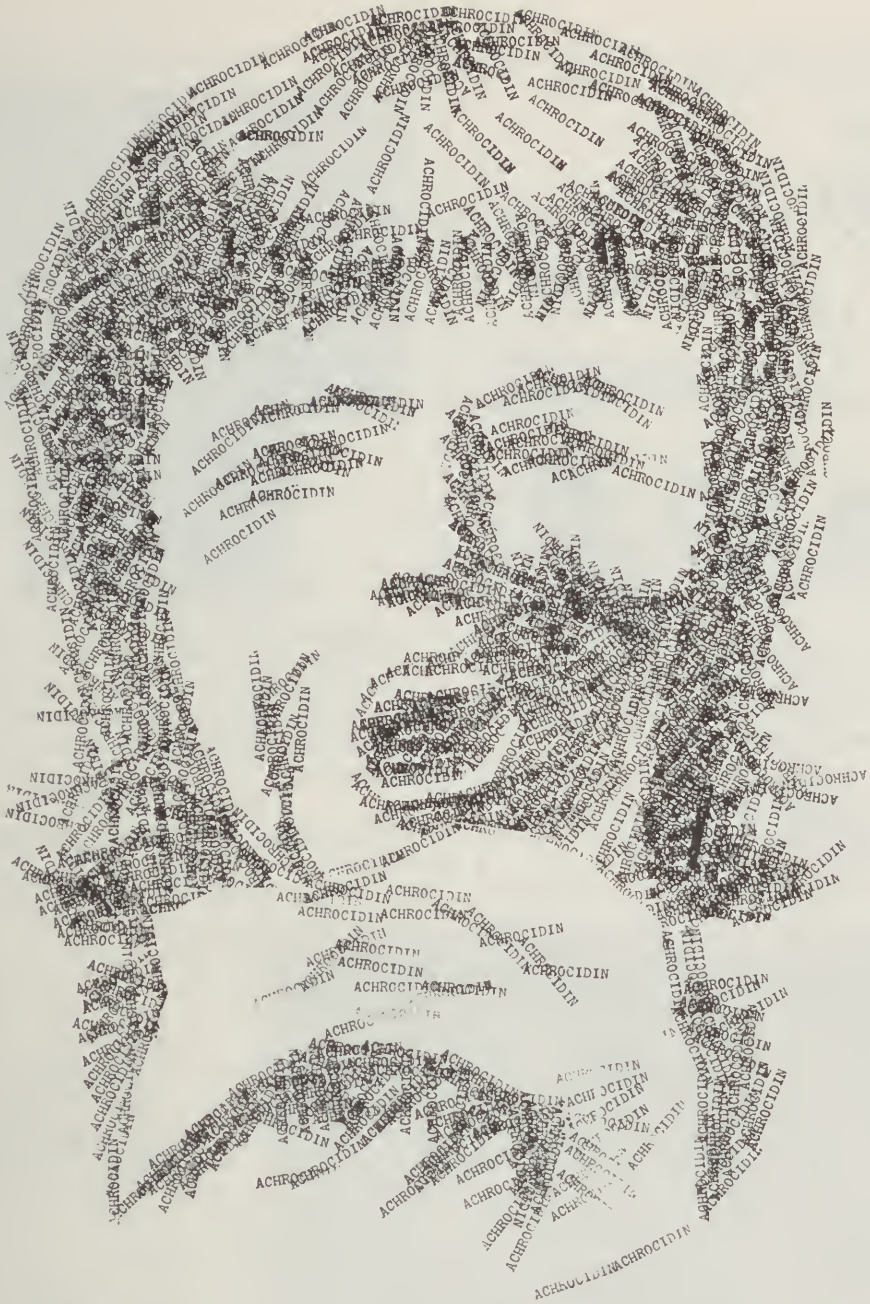
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Nutritional Status of Baltimore City School Children And School Food Program

Within the past two years there has been much public concern over the general nutritional status of school children in the United States. Much of this interest has been generated by cooperative studies conducted in Baltimore city by the Baltimore City Health Department and the Baltimore City Department of Education.

The first of such studies, "Appraising The Health Of Culturally Deprived Children", was conducted from 1963 to 1965 and was published in the October 1967 issue of *The American Journal of Clinical Nutrition*. This was a health evaluation of children enrolled in the city's Early School Admissions program established in 1962 by the Department of Education for pre-kindergarten youngsters of low-income families. The Early School Admissions program was the forerunner of the national Head Start program in Baltimore.

A second study, in 1968, by the City Health Department of a sample of children (2,000) receiving services in the City Health Department's four Comprehensive Children and Youth Health Centers, revealed that many preschool and school-age youngsters were nutritionally deprived to the point of retardation of normal physical growth. These findings prompted the Health Department to urge the Mayor to establish a Task Force on Nutrition to study the problem in Baltimore and to implement programs based on its results. Under Health Department guidance, the Task Force was in operation early in 1969. Its membership contained representatives from every interested and involved governmental agency in the area including the local health department, departments of education and social services, and volunteer groups.

A third study, the most extensive nutrition study-project conducted in Baltimore, was one of several programs implemented upon recommendation of the Task Force. This was a nutritional-status survey of 59,000 school children in the first, second, and third grades of all city public elementary schools. It was this study that was chiefly instrumental in increasing the number of free school lunches in Baltimore city from 1,100 in 1968 to 30,000 by the end of 1969.

The Baltimore nutritional-status survey was conducted in May 1969 not only to establish the extent of malnutrition of children in the primary grades, but also to identify signs of undernutrition to serve as guidelines for principals in determining which children should receive free school lunches.

Accurate assessments of the nutritional needs in large populations have never been easy and always require the exercise of considerable judgment. Five points of investigation have been used in conducting such studies. These are: (1) clinical examinations, (2) biochemical and other laboratory investigations, (3) vital statistics studies, (4) anthropometric data studies, and (5) dietary surveys. In the Baltimore study, in view of limitations of time and staff, it was decided to study three factors—height, weight, and the microhematocrit or blood test for anemia. Ten teams of ten persons each, including physicians, laboratory technicians, public health nurses and health aides, were organized. All technicians were provided through the cooperation of local hospitals. All others were provided by the Department of Health.

Results of the survey are still under study. Preliminary evaluation has shown that of 21,617 children blood tested for anemia, a total of 8,792 had microhematocrits of 36 and below, a level which indicates nutritional anemia. In addition, 541 of these children had readings of 30 or below—a condition of undernutrition severe enough to warrant closer medical attention and treatment. All in the latter group were referred to local hospitals for further evaluation and follow-up. Extending these figures to the total elementary-school population, it

was estimated that some 50,000 children in grades one through eight were not receiving adequate nourishment at home and should be eligible for free meals through school programs. As mentioned previously, 30,000 of these children are now participating in the school lunch program. In addition, as of October 1969, some 2,600 children were enrolled in the free school-breakfast program.

With the preliminary results of the nutrition study in hand, the Mayor's Task Force was able to prompt the city government to increase its appropriation for free and reduced-cost lunches from $100,000 to $553,000. A "hunger banquet" held by the Maryland Food Committee, Inc., a group of interested private citizens, raised additional monies for the school lunch program. Furthermore, additional funds were obtained to establish school food service centers to supply free and reduced-cost meals to 63 schools where no food was available before. This total is slightly less than half the total number of 150 elementary schools in the city.

Baltimore city has made a good start in improving the nutritional status of its school children. Hopefully, these and continuing efforts will contribute immeasurely to the future mental and physical health of its citizens.

John B. Saratsiotis, MD, MPH, and Joseph Gordon

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rehabilitation notes

Renal Involvement in Spinal Cord Injuries

The Geigy Pharmaceuticals Company has published an excellent summary of present knowledge and management of spinal cord injuries. It is largely the work of Dr. Alain Rossier, a paraplegic, and represents the experience in the rehabilitation of paraplegics in Switzerland in the last 15 years. It is concerned primarily with bladder reeducation, bowel reeducation, and reeducation of the locomotor system. This is a well-printed, well-illustrated pamphlet of about 100 pages with a minimal amount of drug advertising. The approach is conservative. The work of Kessler, Guttmann, Bors, Bunts, Commar, Munro, Talbot, and many other authorities on spinal cord injury are quoted throughout.

The author estimates that 40% to 60% of paraplegics are able to dispense with a portable urinal. Some authorities estimate that as high as 78% of patients achieve satisfactory bladder control. One must accept these results with a great deal of skepticism. It may be that as many as 78% achieve satisfactory bladder control for a short period sometime during their hospitalization or thereafter, but it seems quite unlikely that 78% of the patients can maintain satisfactory bladder control for any prolonged period of time. This statement also brings up the meaning of "satisfactory". There is general agreement that the prognosis in paraplegia *quo ad vitam* lies in the patient's kidneys. In one series, made up mainly of children with congenital paraplegia, all deaths were attributed to chronic pyelonephritis. Another series from three Canadian clinics recorded 50% of deaths were due to genitourinary infections. From the United States Veterans Administration, 27 of 59 deaths, in 1960 and 1961, were due to kidney disease. In England, Guttmann reported that 20 of 26 patients whose deaths were due to spinal injuries, died of renal failure. Thus, present methods of bladder care in spinal cord injuries are unsuccessful in preventing late renal complications.

A second problem is the breakdown of the skin, which is almost universal in paraplegics treated in general hospitals. It is difficult to find figures as to how many patients admitted directly to paraplegic centers do not develop decubitus ulcers. The use of the Stryker pad and floating mattresses may be of some help here, but they are not to be considered panaceas.

A review of literature on cordotomy emphasizes that careful consideration is necessary before deciding to operate. The literature here summarized shows a surprising number of good results following cordotomy. The neurosurgeons doing the cordotomies, however, were particularly familiar with this procedure in patients with spinal cord lesions. A number of authors reported a surprising number of cordotomies. One series included 45 patients, another series 41 patients.

Emotional problems of paraplegic patients are particularly well summarized. "It must also be borne in mind that while the therapeutic possibilities of bladder, bowel, and motor reeducation constitute a worthwhile objective for the physician, they are not likely to be looked forward to with enthusiasm by the patient, nor are they likely to distract his thoughts from what he was a few weeks earlier—more often than not, a young man in the prime of life and in full possession of his bodily faculties." It usually takes 12 to 18 months of daily contact with comrades similarly afflicted for the paraplegic patient to become resigned to his situation. The author recommends avoiding positive statements to the patient concerning prognosis.

The author warns against pushing motor reeducation to its utmost limits. "Paraplegics are too often required to make heroic efforts to achieve results which, while spectacular and impressive in themselves, cannot be repeated daily during their working life whose ordinary needs are already fatiguing for a normal person." This opinion is typical of the change which has been taking place since World War II when great efforts were made to get patients up on crutches only to find when they were discharged they did not use this method of locomotion.

In brief, this monograph summarizes the conservative treatment of spinal cord injuries during the

last 15 years. There are some new methods and ideas which have been developed over the last few years which have not been included, but these have not yet been fully evaluated.

* * * * *

Tribe and Silver[1] have recently published a summary of the experience at the British National Spinal Injuries Center in regard to involvement of the kidney in spinal cord injuries. In 1944, Dr. Ludwig Guttmann set up the National Spinal Injuries Center at Stoke-Mandeville. Since that time, over 4,000 patients with spinal cord injuries, the majority of traumatic origin, have been seen at the center. Under Dr. Guttmann (now Professor Sir Ludwig Guttmann), a number of important ideas in the management of patients with spinal cord injuries emerged. He challenged the idea that exploratory laminectomy was indicated in the majority of patients with spinal cord injuries. He developed a comprehensive approach to the patient, emphasizing retraining and return to employment. He developed a method of intermittent catheterization which he felt allowed potential function to return before infection interrupted physiological recovery. A special Stoke-Mandeville bed was developed to assure frequent movement of the patient to prevent decubitus ulceration.

His major contribution was the demonstration that simple but meticulous care could delay or prevent many of the complications of urinary infection and skin breakdown. The ward staff was very carefully trained to carry out turning of the patient religiously night and day.

More recently, Sir Ludwig has been interested in the potential in competitive games in helping the patient with spinal cord injury to come back into the stream of normal life. The development of competitive archery, javelin throwing, basketball, and a number of other games in international competition has drawn attention to the potential of many patients with spinal cord injuries.

Tribe and Silver's book on renal failure in paraplegia is another result of the concentration of the paraplegics into a single hospital with permanent follow-up from that center. The term "paraplegia" is used to designate spinal cord injuries at any site. It is based on 220 necropsies and is concerned mainly with renal failure in chronic paraplegia. Forty-six cases (acute paraplegia) died within the first three months. Pulmonary embolism was a common cause of death (16 cases) in this group, although respiratory failure was common in high cervical lesions. Ten patients died from trauma not directly related to the cord injury. It is interesting that none of these early deaths were caused by renal failure. Only 2 out of 43 cases, in which kidney histology was available, showed evidence of pyelonephritis. This is a remarkable change from the experience of World War I where even in early death, kidney involvement was the rule, and very frequently, the cause of death.

Of 174 cases of chronic (living more than three months after paralysis) cases, 123 were of traumatic origin and death was related to paraplegia in 97. In patients dying of renal failure, pyelonephritis was almost always present, but was usually associated with amyloidosis, often with hypertension, and occasionally all three were present. Amyloidosis alone was rare.

These remarks summarize the general part of the book. The remainder is concerned with diagnostic tests of the urinary tract in paraplegics, a section with illustrations of a number of pathological findings, and finally, a discussion of amyloidosis and hypertension in chronic paraplegia. This is the largest and best studied series ever collected. The findings suggest that intermittent catheterization can indeed delay development of severe bladder and kidney infections early in the course of spinal cord injury. However, since all chronic paraplegics had kidney involvement at postmortem, renal infection is still the major block to prolonging the life of paraplegics. We have not found a dependable method of preventing kidney infection over a prolonged period.

REFERENCE

1. Tribe, C. R., and Silver, J. R.: Renal failure in paraplegia. London, Pitman Medical Publishing Co., Ltd., 1969.

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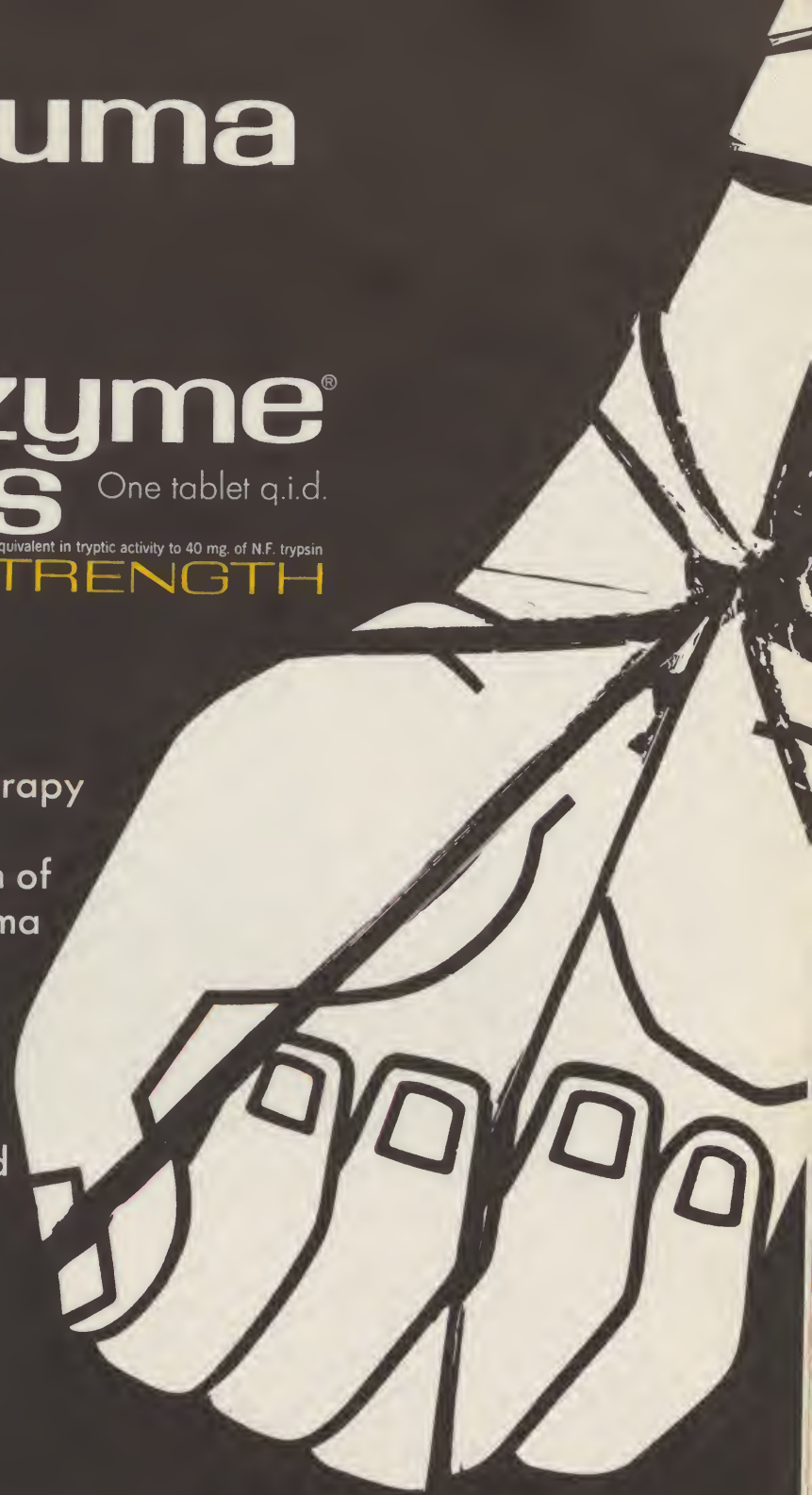
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Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

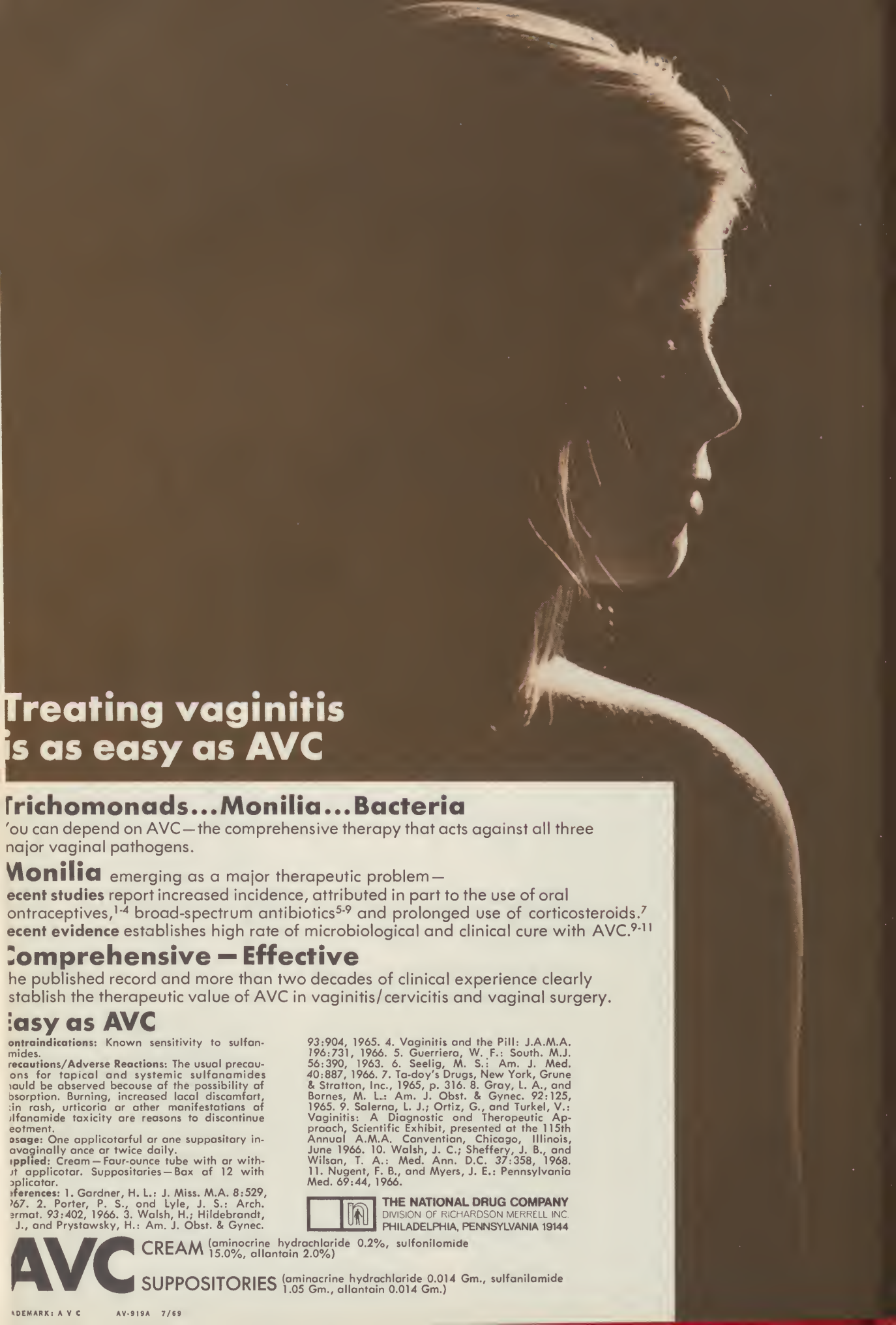
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

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Monilia emerging as a major therapeutic problem—

Recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

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Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

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Dosage: One applicotarful ar ane suppasitary intravaginally ance ar twice daily.

Supplied: Cream—Faur-ounce tube with ar without applicotar. Suppositaries—Bax af 12 with applicatar.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, J., and Prystawsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriera, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-doy's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Theropeutic Appraach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canventian, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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"This Edinburgh catalogue [including some medical theses by American students at Edinburgh] came from Johnston one Sunday morning in 1902, while I was still in Baltimore. I cabled at once for all the American theses—126, excluding those of West Indian students—and secured them. . . . There are theses of some of the most distinguished American physicians: Bard, Archer, Almon of Nova Scotia . . . Shippen, Morgan, Kuhn, Logan of Phila., Benj. Rush, Physick, Arthur Lee, and others. I gave the collection to the Frick Library of the Medical and Chirurgical Faculty of Maryland." *(Osler, Bibliotheca Osleriana #2278)*

One hundred and twenty of the original collection were turned up by the "Ash Project" recently (and perhaps the other six will be found?). Among the surviving, seven are by Marylanders, precious treasure for the Med-Chi, though, of course, they are not the only medical theses by early Maryland physicians in the library. (Unfortunately, Sir William guessed wrong when he cited the Archer thesis. This proves to be John Randolph Archer, not *our* John Archer, but a less significant Virginian.)

In successive order, the earliest of the Marylanders' theses, represented in the câche, is by James Steuart (*De Spasmo,* 1779), who moved from Annapolis to Baltimore in 1780, was Baltimore's Commissioner of Health in 1805, and an active vaccinationist. Next, in point of time, is the thesis of one of Med-Chi's founders, Daniel Moores (*De Febre Remittente Marilandica,* 1787) who practiced in Harford County, later in Baltimore, and was himself a victim of yellow fever in 1802. John Weems (*De Amenorrhoea,* 1792) does not seem to be known in Cordell's *Medical Annals of Maryland,* but his thesis is dedicated, secondarily, to William Beanes, a Med-Chi founder, of "Star Spangled Banner" fame.

We have not researched the reason for the difference, but John Irvine Troup's thesis (*De Lumbricis Intestinorum Teretibus,* 1793) is cited in Cordell as *De Vermibus,* and it is certainly about parasites—perhaps it was also published with that title. Troup practiced on the Eastern Shore and retired near Baltimore, but not much seems to have been written about him. We have a little better picture of founder Percy Eccleston Noel (*De Angina Tracheali,* 1794), for Cordell commenting on an extant pencil profile says, in part, that he had "a frank, sociable, amiable countenance", which probably endeared him to his patients in Queen Anne's County before his death at 45.

Two of the Maryland theses are of the 19th century. One is William Gibson's "Civis Americanus, de Baltimore" (*De Forma Ossium Gentilitia,* 1809). He was also a house pupil of Charles Bell in London which, with some practical experience, probably brought him to be the first to ligate the common iliac artery in 1812 (Garrison/Morton 2944). His other contributions to American medicine are well known, and he is surely the most influential physician represented in the present lot. The last of this clutch of Maryland theses is by John Revere (*De Insania,* 1811), Paul Revere's youngest son, who left the New England climate for the central states, and remained in Baltimore for about 15 years, mid-course in an eventful career.

Would there were space for descriptions of the other theses! Perhaps at another time? Meanwhile, these 120 theses are kept together with the Osler books and are available for research.

New Accessions
BOOKS
(Arranged by Author and Title)

Ackerknecht, E. H.
A short history of medicine. Rev. print. New York, Ronald Press, 1968.

Advances in surgery, v. 3-
Chicago, Year Book Medical Pub. Editors: 1968— C. E. Welch and others.

American Cancer Society. Massachusetts Division
Cancer; a manual for practitioners. 4th ed. Boston, 1968.

American College of Neuropsychopharmacology
Drug abuse; social and psychopharmacological aspects. Compiled and edited by Jonathan O. Cole and J. R. Wittenborn. Springfield, Ill., Thomas, 1969.

American Nurses Association
Facts about nursing; a statistical summary, 1969 edition. New York, 1969.

Applied Seminar on the Laboratory Diagnosis of Liver Diseases, Washington, 1966
Laboratory diagnosis of liver diseases; proceedings. Compiled and edited by F. William Sunderman and F. William Sunderman, Jr. St. Louis, Green, 1968.

Bayne-Jones, Stanhope
The evolution of preventive medicine in the United States Army, 1607-1939 Washington, Office of the Surgeon General, Dept. of the Army, 1968.

Blaiberg, Philip
Looking at my heart. New York, Stein and Day, 1968.

Botsford, T. W.
The acute abdomen. By Thomas W. Botsford and Richard E. Wilson. Philadelphia, Saunders, 1969. (Major problems in clinical surgery v. 10)

Bray, Patrick F.
Neurology in pediatrics. Chicago, Year Book Medical Pub., 1969.

Cailliet, René
Low back pain syndrome. 2d ed. Philadelphia, Davis, 1968.

Conference on Cell Cultures for Virus Vaccine Production, National Institutes Health, 1967
Cell culture for virus vaccine production. Conference chairman and editor: Donald J. Merchant. Bethesda, U.S. National Cancer Institute, 1968. (U.S. National Cancer Institute. Monograph no. 29)

Cooper, Irving S.
Involuntary movement disorders. New York, Hoeber, 1969.

Davidsohn, Israel
Todd-Sanford clinical diagnosis by laboratory methods. Edited by Israel Davidsohn and John Bernard Henry. 14th ed. Philadelphia, Saunders, 1969.

Davson, Hugh
Principles of human physiology. Edited by Hugh Davson and M. Grace Eggleton. 14th ed. Philadelphia, Lea & Febiger, 1968.

DeRopp, Robert S.
Sex energy; the sexual force in man and animals. New York. Delacorte Press, 1969.

Drugs and the brain; papers on the action, use, and abuse of psychotropic agents. Edited by Perry Black. Baltimore, Johns Hopkins Press, 1969.

Dunlop, Derrick M.
Textbook of medical treatment. Edited by Sir Derrick Dunlop, Stanley Alstead and Alastair G. Macgregor. 11th ed. Baltimore, Williams & Wilkins, 1968.

Everson, Tilden C.
Cancer of the digestive tract; clinical management. Editors: Tilden C. Everson and Warren H. Cole. New York, Appleton-Century Crofts, 1969.

Greenhill, Jacob P.
Surgical gynecology, including important obstetric operations. 4th ed. Chicago, Year Book Med. Pub., 1969. (Handbook of operative surgery)

Hepner, James O.
Personnel administration and labor relations in health care facilities. By James O. Hepner, John M. Boyer and Carl L. Westerhaus. St. Louis, Mosby, 1969.

Hinshaw, Horton C.
Diseases of the chest. 3d ed. Philadelphia, Saunders, 1969.

Hoops, Richard A.
Speech science; acoustics in speech. 2d ed. Springfield, Ill., Thomas, 1969.

International Conference on Facial Pain, Atlantic City, 1967
Facial pain. Editor: Charles C. Alling. Philadelphia, Lea & Febiger, 1968.

Invitational Conference on Hospital Involvement in Regional Medical Programs, Chicago 1968
Proceedings of the Invitational Conference on Hospital Involvement in Regional Medical Programs. June 13-14, 1968. Chicago, American Hospital Assn., 1969.

Kesten, Yehuda
Diary of a heart patient; twice operated on by Dr. DeBakey, a patient tells of his own experience. New York, McGraw-Hill, 1968.

Kistner, Robert W.
The use of progestins in obstetrics and gynecology. Chicago, Year Book Medical Pub., 1969.

Kyle, David
Minor surgery. London, Butterworths, 1968.

Macleod, John
Clinical examination; a textbook for students and physicians by teachers of the Edinburgh Medical School. 2d ed. Edinburgh, Livingstone, 1967.

Marshak, Richard H.
Radiology of the small intestine. By Richard H. Marshak and Arthur E. Lindner. With a chapter on the small bowel in infants and children by John E. Moseley and Jack G. Rabinowitz and with a chapter on unconscious lesions by Arthur R. Clemett. Philadelphia, Saunders, 1970.

Masters, William H.
Human sexual inadequacy. By William H. Masters and Virginia E. Johnson. Boston, Little, Brown, 1970.

Matson, Donald D.
Neurosurgery of infancy and childhood. 2d ed. Springfield, Ill., Thomas, 1969.

May, Charles H.
Manual of the diseases of the eye for students and general practitioners. 24th ed., rev. and edited by James H. Allen. Baltimore, Williams & Wilkins, 1968.

Microbiology; proceedings of a conference held in London, Sept. 19-20, 1967
Edited by Peter Hepple. London, Institute of Petroleum, 1968.

Microsurgery of the eye. Edited by G. Mackensen, M. J. Roper-Hall and R. C. Trautman. Basel, New York, Karger, 1968. (Bibliotheca ophthalmologica, fasc. 77)

Muehrcke, Robert C.
Acute renal failure: diagnosis and management. St. Louis, Mosby, 1969.

National Conference on Medical Malpractice. 1st, Chicago, 1970
Report. Conference sponsored by the American Osteopathic Association with the support of the U.S. Dept. of Health, Education and Welfare. Chicago, American Osteopathic Association, 1970.

Nyhus, Lloyd M.
Hernia. Editors: Lloyd M. Nyhus and Henry N. Harkins. Philadelphia, Lippincott, 1964.

Pohlman, Edward H.
The psychology of birth planning. By Edward Pohlman with the assistance of Julia Mae Pohlman. Cambridge, Schenkman, 1969.

The Psychodynamics of change of sex through surgery. Baltimore, Williams & Wilkins, 1969. (Journal of Nervous and Mental Disease, v. 147, 1968)

Sloane, Nathan H.
Review of biochemistry. By Nathan H. Sloane and J. Lyndal York. New York, Macmillan, 1969.

Smith, R. L.
At your own risk; the case against chiropractic. New York, Trident Press, 1969.

Starzl, Thomas E.
Experience in hepatic transplantation. By Thomas E. Starzl and Charles W. Putnam. Philadelphia, Saunders, 1969.

Stein, Calvert
Practical family and marriage counseling. Springfield, Ill., Thomas, 1969.

Stock, Claudette
Minimal brain dysfunction child; some clinical manifestations, definitions, descriptions and remediation approaches. Boulder, Colo., Pruett Press, 1969.

Stokes, E. J.
Clinical bacteriology. 3d ed. Baltimore, Williams & Wilkins, 1968.

Symposium on Comparative Morphology of Hematopoietic Neoplasms, Armed Forces Institute of Pathology, 1968
Comparative morphology of hematopoietic neoplasms. Editors: Carolyn H. Lingeman and F. M. Garner. Bethesda, U.S. National Cancer Institute, 1969. (U.S. National Cancer Institute. Monograph no. 32)

Symposium on Neoplasms and Related Disorders of Invertebrate and Lower Vertebrate Animals. Smithsonian Institution, 1968
Neoplasms and related disorders of invertebrate and lower vertebrate animals. Chairmen and editors: Clyde J. Dawe and John C. Harshbarger. Bethesda, U.S. National Cancer Institute, 1969. (U.S. National Cancer Institute. Monograph no. 31)

Symposium on the Treatment of Diabetic Retinopathy, Airlie House, 1968
Symposium on the Treatment of Diabetic Retinopathy. Edited by Morton F. Goldberg and Stuart L. Fine. Arlington, Va. U.S. Neurological and Sensory Disease Control Program, Washington, 1969.

Szent-Gyorgyi, Albert
Bioelectronics; a study in cellular regulations, defense, and cancer. New York, Academic Press, 1968.

Theodore, C. N.
Selected characteristics of the physician population, 1963 and 1967. By C. N. Theodore, J. N. Haug, assisted by B. C. Martin. Chicago, American Medical Association, Dept. of Survey Research, 1969.

Thorne, F. C.
Psychological case handling. 2d ed. Brandon, Vt., Clinical Psychology Pub. Co., 1968.

Turell, Robert
Diseases of the colon and anorectum. 2d ed. Philadelphia, Saunders, 1969.

Urry, D. W.
Spectroscopic approaches to biomolecular conformation. Edited by D. W. Urry. Chicago, American Medical Association, 1970.

Useller, J. W.
Clean room technology. Washington, Technology Utilization Division, National Aeronautics and Space Administration, 1969.

U.S. Library of Congress. National Referral Center for Science and Technology
A directory of information resources in the United States: general toxicology. Washington, 1969.

U.S. National Center for Health Statistics
International classification of diseases, adapted for use in the United States. 8th revision. Washington, 1969.

U.S. National Clearinghouse for Mental Health Information
Mental health directory, 1970. Chevy Chase, Md., U.S. National Institute of Mental Health, 1970. (U.S. National Clearinghouse for Mental Health Information. Publication no. 1005)

U.S. National Communicable Disease Center, Atlanta. Venereal Disease Program
Manual of tests for syphilis, 1969. Rev. Jan. 1969. Washington, U.S. Govt. Print. Off. 1969.

White, Abraham
Principles of biochemistry. By Abraham White, Philip Handler and Emil Smith. 4th ed. New York, McGraw-Hill, 1968.

Winokur, George
Manic depressive illness. By George Winokur, Paula J. Clayton and Theodore Reich. St. Louis, Mosby, 1969.

Witten, D. M.
The breast. Chicago, Year Book Medical Publishers, 1969. (Atlas of tumor radiology, v. 6)

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DATES OF IMPORTANCE TO ALL PHYSICIANS, THEIR WIVES, AND GUESTS

Thursday, Friday, Saturday, September, 10, 11, 12, 1970
at the
Hotel Hershey, Hershey, Pennsylvania

The Semiannual Meeting in Hershey, which proved so successful in 1969, has again been scheduled in that location with even more attractive events for all.

THURSDAY, SEPTEMBER 10

Executive Committee and Council Meetings

Monte Carlo Night—8:30 PM—a real family night of fun

FRIDAY, SEPTEMBER 11

Business Meetings: House of Delegates—9:30 AM
Woman's Auxiliary—9:30 AM

Scientific Program on Environmental Pollution—11:00 AM
A panel discussion of interest to all physicians, their wives, and guests

MMPAC Luncheon Meeting—1:00 PM
A meeting of the Maryland Medical Political Action Committee, with a prominent speaker of interest to everyone

Tour of Hershey Medical Center—2:30 PM
This tour will include the Medical Sciences Building and Teaching Hospital, plus the animal facilities for those who are interested. Physicians and their guests are invited.

Golf Tournaments—Men's—1:00 PM at the Hershey Country Club
Ladies'—1:00 PM at Hotel Hershey
Mixed—2:00 PM at Hotel Hershey

Cocktail Party and Banquet—7:00 PM
Entertainment by MARK RUSSELL, well-known Washington wit and pianist

SATURDAY, SEPTEMBER 12

Scientific and Business Meetings
Maryland Chapter, American College of Surgeons
Maryland Diabetes Association
Maryland Society for the Rheumatic Diseases
Maryland Association of Physicians in Chronic Disease Facilities
Board of Directors, Maryland Academy of General Practice

Tours of interest to all—to be announced

Cocktail Party and Dinner Dance—7:00 PM
Plus entertainment planned by the Woman's Auxiliary

Have you made your hotel reservation? If not, fill in the reservation form and mail today. The Semiannual Meeting will provide a weekend of postgraduate education plus many forms of entertainment and relaxation. The complete program and reservation form for the various events will be mailed to all members of the Faculty in August and will also be included in the August issue of the JOURNAL. If you are not a member of the Faculty and wish a copy of the program and reservation form, please contact the Faculty office.

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Arlie R. Mansberger, Jr., MD, Chairman
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For hotel reservation form, see page 7.

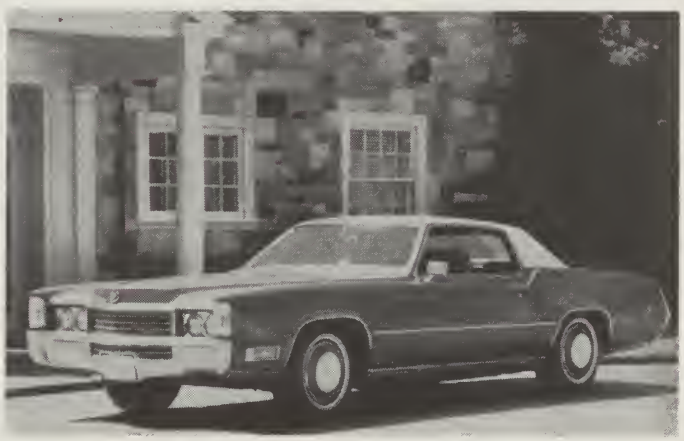
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Certified Medical Representatives Institute Research Study

The first phase of a broad research study for the Certified Medical Representatives Institute was conducted during the months of August, September, and October 1966. Two thousand physicians, dentists, and pharmacists were surveyed by mail to determine their attitudes concerning pharmaceutical company representatives and to determine their reactions to the proposed Certified Medical Representative Program. A small sample of detailmen, working in the Richmond and Roanoke, Virginia areas, was interviewed for their opinions and reactions.

Approximately 23% of the professional groups contacted returned the survey forms and many of the individuals wrote extensive comments. Data obtained, concerning years in practice and field of specialty, indicate returns from a representative cross section of the medical field.

Professionals and detailmen were in general agreement on the primary issues, although there were small percentage differences in the different geographical areas. The results showed:

(1) Professional groups agree that the pharmaceutical representative serves an important function. Three fourths of the physicians and dentists and over 80% of the pharmacists see a need for contacts by medical representatives. About one out of ten individuals surveyed view the detailmen as a nuisance and unnecessary.

(2) Medical groups see a definite need for greater training and specialization of medical representatives. Only one out of four professionals think that the pharmaceutical representatives are well trained. In response to an open-end question concerning the training of the pharmaceutical representative, the majority of the comments were negative.

(3) Detailmen and professionals feel that the CMR Program is a positive solution to the need for more knowledge and training. Eighty-four percent of the detailmen interviewed and over 70% of the professionals believe that the CMR Program would be valuable. In a free-response question, there were three times as many positive responses concerning the value of the CMR Program as negative responses.

(4) Suggestions for appropriate and important courses to accomplish the goals of the CMR Program were consistent among the professional groups in the different geographical areas. Pharmacology, medical terminology, physiology, and chemistry were considered important in all subsamples. The pharmacists, more than the other professional groups, believe that business and self-improvement courses would be desirable.

Further phases of the CMR research study will involve:

(1) Additional mail surveys of professional groups in 10 to 15 different geographical areas

(2) In depth interviews with selected professional personnel

(3) Conferences with sponsoring manufacturers

(4) Several group meetings with medical representatives.

The curriculum developed for the Certified Medical Representatives Institute was based upon initial survey results. Exact course content was determined by studies still in progress and consultations during the course development. Courses in economics and business psychology were offered first, followed by technical courses. The CMR educational program involved a variety of self-study instructional techniques. Programmed instruction was used extensively, although this necessitated a longer development period for some subjects. General texts, special study guides, workbooks, and review procedures were also used.

The two-year CMR study program contains approximately 300 hours of study time. There are individual variations in the amount of time spent on various programs, depending on the amount of related background work. If a course requires previous knowledge about a particular subject, review procedures and supplementary study guides are provided.

To obtain certification and be designated as a Certified Medical Representative, a pharmaceutical representative, sponsored by his company, will be required to pass five parts of a certification examination. Examinations will be administered throughout the country several times during the calendar year. A representative ordinarily would take one part of an examination at a time, with subject areas grouped as below.

Part I (Economics and Psychology)

Part II (History of the Pharmaceutical Industry, Government Regulations, and Professional Ethics)

Part III (Pharmacology and Medical Terminology)

Part IV (Chemistry and Research Methods)

Part V (Medical Sciences)

Every effort is made to develop meaningful and valuable course content so that individuals becoming certified will readily obtain professional recognition by medical groups.

Participating pharmaceutical companies include: CIBA Pharmaceuticals, Dorsey Laboratories, A. H. Robins, Syntex Laboratories, and Warner-Chilcott Laboratories.

Ed. Note: Results from the 1,160 questionnaires that were returned to the Faculty offices, concerning Faculty activities, show physicians feel that detailmen should be accredited (493 said yes, 359 said no). However, they felt that the detailmen should not be licensed (294 to 597). Finally, an overwhelming majority (771 to 142) thought that the representatives should be required to have continuing education.

It's in the Negative

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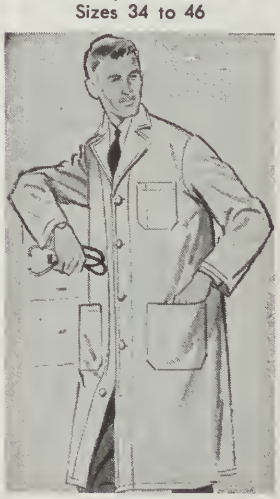
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Advertisers in This Issue

A & F Nurses Registry 25
Abbey Rents 14
Aids For Hearing, Inc. 101
American Office Equipment Co., Inc. 31
Arch Laboratories 72
Arundel Federal Savings & Loan Assoc. 84
Atlantic Sands Motel 82
Baltimore Federal Savings & Loan Assoc. .....Cover 3
Baltimore Nurses Exchange 88
Baltimore Oxygen Supply Co., Inc. 98
Beach Plaza Hotel & Bo-Con Apts. 82
Belvedere Hotel 25
Breon Laboratories 29
Bryman School 84
Burroughs Wellcome & Co. 78
Campbell Soup Co. 41
Capital Savings & Loan Assoc. 25
Oscar Caplan & Sons 8
Cobb-Woods Services 97
Coca-Cola Bottling Co. 84
Conal Pharmaceuticals 44
Connecticut Mutual Life Insurance Co. 17
Convention & Civic Center—Rehoboth Beach 82
Credit Service International, Inc. 25
Dow Chemical Co. 77
Dulaney Towson Nursing & Conv. Home 94
Eleven East Chase Street Corp. 94
Embassy Dairy 14
Esplanade Apartments 74
Flint Laboratories 26
Forty West Porsche Audi, Inc. 18
Franklin Uniform Co. 100
Geigy Pharmaceuticals 80-81
Hanna Rug Co. 94
House in the Pines Nursing Homes 86
Hynson, Westcott & Dunning, Inc. 1
Intercharge Systems, Inc. .....Cover 2
Koch Associates 14
Lederle Laboratories 2, 18, 32, 83
Eli Lilly & Co. 4
Mario's Restaurant 45
Martin Motors, Inc. 25
Michaelson Motors, Inc. 102
Milton Inn 45
Monarch Lincoln Mercury 95
National Drug Co. 15-16, 89-90
Chas. Pfizer & Co., Inc.
Pfizer Laboratories Division 46-47
Wm. P. Poythress Co., Inc. 79
T. Rowe Price Growth Stock Fund, Inc. 86
Geo. Radebaugh & Sons 11
Read's Drug Stores 18
Resinol Chemical Co. 76
Roche Laboratories .....Cover 4
Schering Corporation 21-24
Manuel Schwartz Hearing Rehabilitation 88
G. D. Searle & Co. 42-43
Security Business Services, Inc. 98
Special Diet Shop 98
Sterling Lighting Co. 98
Stowaway Motel 82
Stuart Pharmaceuticals
(Division of Atlas Chemical Industries, Inc.) .. 12
Swartz Cadillac Co. 97
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 8
Timonium Chrysler Plymouth 11
Tio Pepe Restaurant 45
Towson Telephone Secretaries 97
Towson Valley Motors 98
D. Stuart Webb Advertising Services, Inc. 100
Webb Printing Co. 14
White Rice Inn 45
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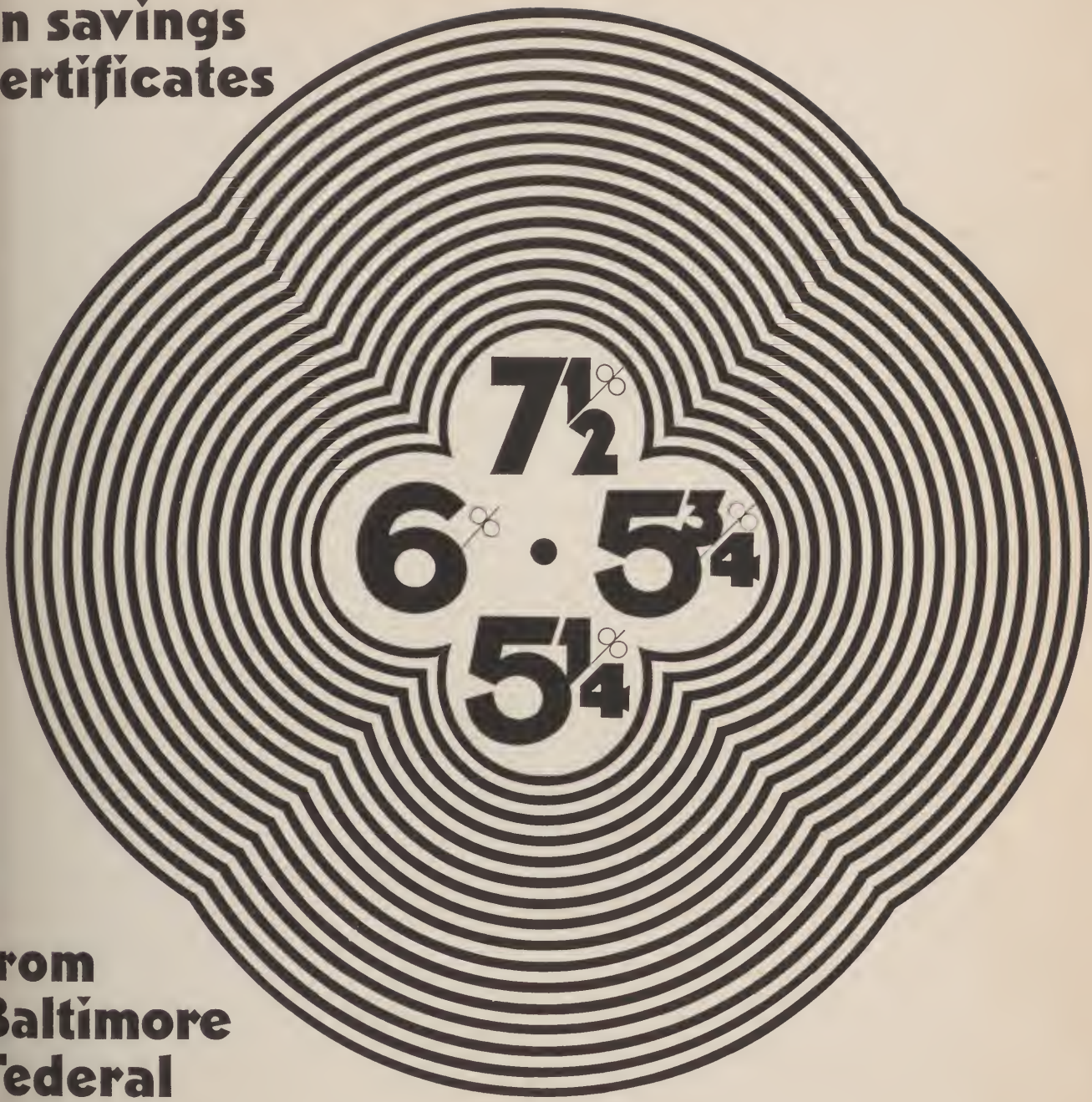


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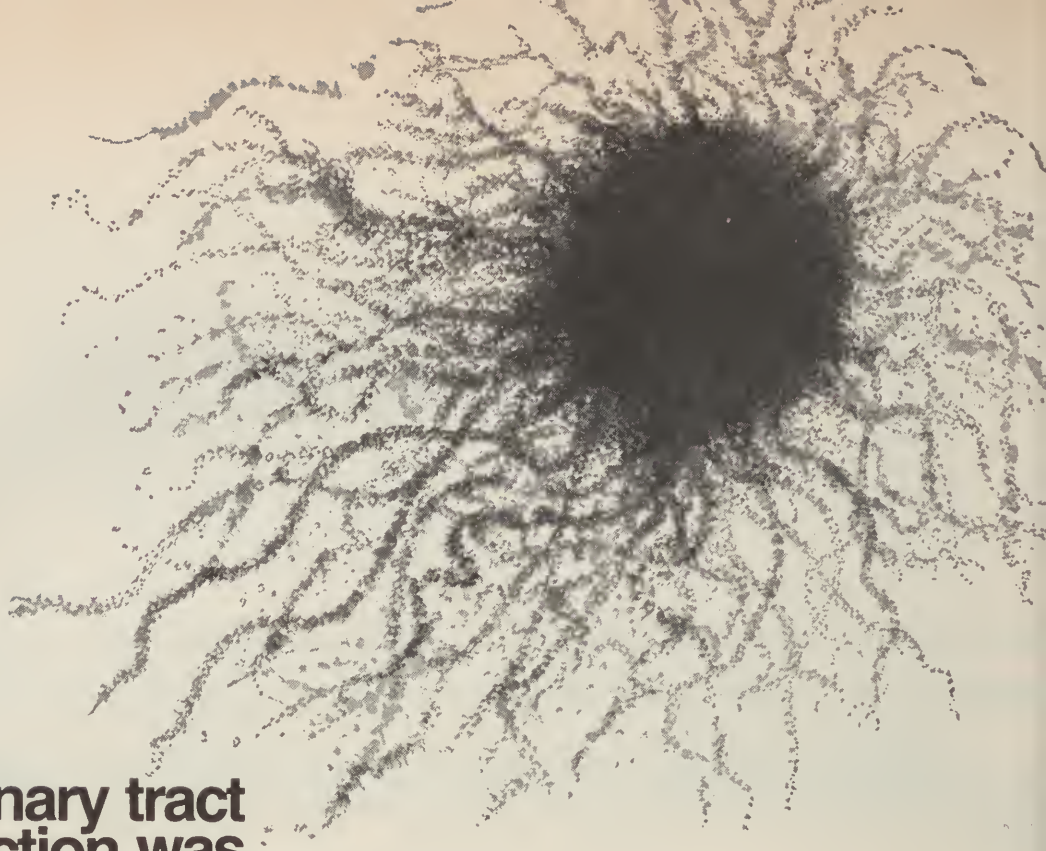
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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VOLUME 19 AUGUST 1970 NUMBER 8

CONTENTS:

Reflections on the 1968 Olympics Conducted at High Altitude, Thomas F. Waddell, MD 59

"The prime reason for our success at the 1968 Olympics was our early formation and training at Lake Tahoe."

Physical Medicine in Athletic Rehabilitation, Alvin M. Brown, MD .. 61

"Heat and cold are the two most generally accepted physical measures used in modern athletic rehabilitation. However, therapeutic exercises, massage, splinting, and compression bandaging are becoming increasingly more important in the restoration of the injured athlete to maximal functional capacity."

Athletic Competition for Girls, Tenley Albright, MD 65

"A superbly fit athlete with a love for her sport is hard to hold down. Her enthusiasm for her sport is bound to reflect in her enthusiasm for life and for whatever else she does. Yet, I feel that we, who are in the position to do otherwise, have neglected to encourage young women to participate in competitive sports."

The Use of Drugs in Athletics, William J. Kinnard, Jr., PhD 67

"A major problem today is drug abuse among young people. We, as adults, must help them develop the respect for drugs that can only come from their judicious use. Let's be sure that we are working with the "natural" athlete and not one who, through the excessive use of drugs, is forced to perform at a level far past his normal limitations."

The Use of Drugs in Athletics, Gary G. Buterbaugh, PhD 69

"The special health hazards inherent in athletics often lead to valid medical reasons for administering a drug or drugs to an athlete. It must be emphasized that these 'restorative' drugs are not intended to be administered to an injured athlete for the purpose of allowing him to continue competition in spite of the injury."

Psychological and Psychosomatic Problems of Athletes, Burris F. Husman, EdD 71

"The psychological problems of athletes are those related to behavior. Likewise, anything influencing the mental processes or behavior of the athlete can have an effect on him physically."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 78

Library Page—Medical Library Association Conference—1970, New Accessions 87

Maryland State Department of Health and Mental Hygiene—The National Scene 93

Baltimore City Health Department—Smoking and Health 95

Tuberculosis—The Public Health Clinic—Its Place in Comprehensive Health Care 97

Alcoholism—The Alcoholism Counselor in a General Hospital, Clarence W. Hurley, Jr. 100

Heart Page—Dietary Salt (Sodium Chloride) Intake and Arterial Hypertension: Part 1, Elijah Saunders, MD 103

Rehabilitation Notes—Rehabilitation Needs of Patients with Spinal Cord Injuries, Douglas G. Carroll, MD 105

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Be sure to attend the Semiannual Meeting in Hershey, Pennsylvania on September 10-12, 1970. See this Journal for details.

Doctors Take Note 5

Executive Director's Newsletter 9

Semiannual Meeting Hotel Reservation Form 14

Component Society News 17, 35, 57

Semiannual Meeting Golf Registration Form 20, 29

Semiannual Meeting Program 21

Semiannual Meeting Activities Registration 31

Book Reviews 33

Annual Meeting Scientific Exhibit Form 36

Medical News 39

The Month in Washington 45

Woman's Auxiliary 51

Letters to the Editor 55

Results of Faculty Questionnaire 83

Information for Authors 94

Classified Advertising 109

Advertising Index 110

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AUGUST 20-22, 1970
DIVISION OF CLINICAL ONCOLOGY, UNIVERSITY OF WISCONSIN

9th National Conference on Therapies for Advanced Cancers: University of Wisconsin Postgraduate Center, Madison, Wisconsin. Chairman: Fred J. Ansfield, MD, Professor of Clinical Oncology. For additional information, write: R. J. Samp, MD, Program Coordinator, University Hospitals, Madison, Wisc. 53706.

AUGUST 23-28, 1970
INTERNATIONAL DIABETES FEDERATION

Seventh Congress: Buenos Aires, Argentina. The program will consist of symposia, lectures, and conferences. Write: VII Congreso, Federacion Internacional De Diabetes, Dr. V. G. Foglia, Paraguay 2155-7° Buenos Aires, Argentina.

SEPTEMBER 1-3, 1970
AMERICAN COLLEGE OF PHYSICIANS

Course—Dermatological Diagnosis and Treatment for the Internist: University of Maryland School of Medicine, Redwood & Greene Sts., Baltimore, Md. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

SEPTEMBER 6-12, 1970
AMERICAN HEART ASSOCIATION

6th World Congress of Cardiology: London, England. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

SEPTEMBER 8-11, 1970
FEDERATION OF FRENCH SPEAKING SOCIETIES OF GYNECOLOGY AND OBSTETRICS

23rd Congress: Brussels, Belgium. Write: Prof. R. Vokaer, Secretaire General du Congres, Service de gynecologie et obstetrique, Hopital Brugmann 4, Place van Gehuchten, Bruxelles 2, Belgique.

SEPTEMBER 9-11, 1970
NATIONAL INTERAGENCY COUNCIL ON SMOKING AND HEALTH

National Conference: Town and Country Hotel, San Diego, California. Contact: Roger Schmidt, (212) 532-6035 (New York city).

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Postgraduate Course—Renal Diseases: Pathophysiology, Diagnosis and Management: Mayo Graduate School of Medicine and Mayo Clinic, Rochester, Minnesota. Contact: American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

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Postgraduate Course—Advances in Internal Medicine: Department of Medicine, University of California, San Francisco, California. Contact: American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

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Short Course—General Internal Medicine: Bethesda, Md. Contact: L. M. Fox, Capt. MC USN, U. S. Naval Hospital, National Naval Medical Center, Bethesda, Md. 20014.

SEPTEMBER 17-19, 1970

AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY

Annual Meeting and Scientific Session: Shoreham Hotel, Washington, D.C. Write: Philip T. White, MD. Secretary, Marquette School of Medicine, 8700 West Wisconsin Avenue, Milwaukee, Wisc. 53226.

SEPTEMBER 19-20, 1970

JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION

3rd National Congress on Medical Ethics: Chicago, Illinois. Contact: American Medical Association, Judicial Council, 535 North Dearborn Street, Chicago, Ill. 60610.

SEPTEMBER 19-25, 1970

DEPARTMENT OF OTOLARYNGOLOGY, UNIVERSITY OF ILLINOIS

Annual Otolaryngologic Assembly: Eye and Ear Infirmary of the University of Illinois Hospital, Chicago, Illinois. The Department offers a condensed postgraduate basic and clinical program for practicing otolaryngologists. Write: Otolaryngology, P.O. Box 6998, Chicago, Illinois 60680.

SEPTEMBER 22, 1970

JOINT ANESTHESIA STUDY COMMITTEE/BALTIMORE CITY MEDICAL SOCIETY/BALTIMORE CITY HEALTH DEPARTMENT

Meeting—Anesthesia for Surgery of the Eye and Medicolegal Implications: 7:30 PM, Osler Hall, 1211 Cathedral St., Baltimore, Md. Contact: Calbert T. Seebert, MD, University of Maryland Hospital, Department of Anesthesiology, Redwood & Greene Sts., Baltimore, Md. 21201.

SEPTEMBER 22-25, 1970

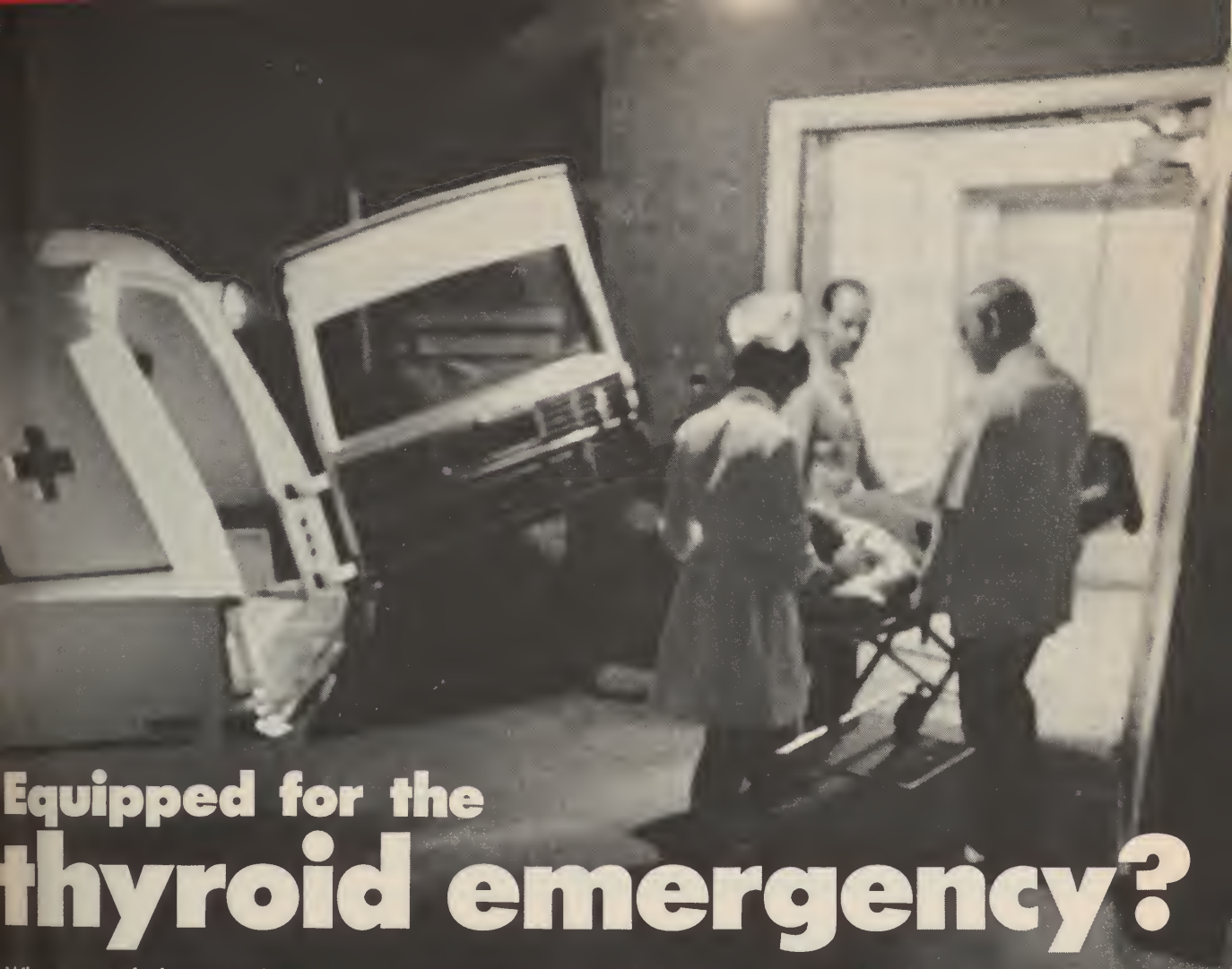
SLOVAK MEDICAL SOCIETY

1st Danube Congress of Obstetrics and Gynecology: Bratislava, Czechoslovakia. Contact: Slovak Medical Society, Congress Office Bratislava, Mickiewiczova 18 Czechoslovakia.

OCTOBER 4-9, 1970

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PRECAUTIONS: As with other thyroid preparations, overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, insomnia and continued weight loss. These effects may become apparent in from 4 days to three weeks. Therefore, patients should be kept under close observation. Medication, in such cases, should be stopped for 2 to 6 days, then resumed at a lower level. In patients with diabetes mellitus, look for possible changes in metabolic activity which may affect insulin or other antidiabetic drug dosage requirements.

CONTRAINDICATIONS: Thyrotoxicosis, acute myocardial infarction.

SIDE EFFECTS: Side effects are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, weight loss, diarrhea, vomiting and nervousness. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. In most cases, a reduction in dosage followed by a more gradual adjustment upward will indicate the patient's dosage requirements without the appearance of side effects.

DOSAGE AND ADMINISTRATION: In myxedematous stupor or coma, with no evidence of severe heart disease, 200 to 400 mcg. of SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing a solution containing 100 mcg. per ml. Detectable effects are usually observed by the sixth hour after injection and are fully appreciated during the following day. A repeat injection of 100 to 200 mcg. may be given on the second day if significant improvement has not occurred. The intravenous use of sodium levothyroxine in myxedematous coma is advantageous because it produces a predictable increase in the concentration of protein-bound iodine, eliminates the need for multiple doses until oral therapy is reinstated, circumvents the uncertainty of oral absorption, and avoids the risk of pulmonary aspiration.

SUPPLIED: SYNTHROID (sodium levothyroxine) INJECTION is supplied in 10 ml. vials containing 500 mcg. of lyophilized active ingredient and 10 mg. of Mannitol, N.F.; a 5 ml. vial containing Sodium Chloride Injection, U.S.P. is provided as diluent.

Also supplied as SYNTHROID (sodium levothyroxine) TABLET in color coded compressed tablets, and in seven strengths: 0.025 mg. (orange), 0.05 mg. (white), 0.1 mg. (yellow), 0.15 mg. (violet), 0.2 mg. (pink), 0.3 mg. (green), and 0.5 mg. (blue). Each strength is supplied in bottles of 100 and 500 tablets.

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executive director's newsletter

August, 1970

FINAL PROOF TO PRINTERS

The completely revised and up-to-date book on Laws, Rules And Regulations With Which Physicians Must Comply is now being printed. Copies should be in the mail to all members early in the fall.

Of particular interest to members are new laws concerning admissions to mental health institutions. Where the law touches physicians most directly is in the definitions of mental disorder, mental illness, and mental retardation, and in the provisions dealing with the admission of mentally disordered persons to hospitals. The provisions dealing with "Insanity as a Defense in Criminal Cases" have not changed substantially. See the new book for specifics.

MEDICARE AND MEDICAID RECIPIENTS WILL ALL HAVE MEDICARE PART B

An additional confusion within the Medicaid program will soon be solved when all recipients over age 65 will have Part B of Medicare purchased for them.

Not only will this reduce considerable paperwork for Blue Shield, which must process all such cases before forwarding them to the State Health Department, but it will also provide these people with fully paid medical care.

About 12,000 people are covered and the state will pay about $768,000 for the Part B coverage. The complete program, which took effect July 1, will cost the state about $1 million.

Drugs not covered under the federal program will continue to be paid for under the state's Medicaid program.

NARCOTICS REMINDER

There have been some recent problems involving physician's prescriptions for narcotics. For those physicians unfamiliar with this issue, federal law prohibits refills on any narcotic prescriptions or telephone calls to pharmacists by physicians for narcotic prescriptions.

MARYLAND AUXILIARY WINS AWARDS

The Woman's Auxiliary to the Faculty won an award for the greatest increase (408.90%) of any state in the collection of AMAERF funds. The state's

MARYLAND AUXILIARY WINS AWARDS (cont'd)

contribution to the national fund totaled $29,492.45 (June 1, 1969 to May 31, 1970). In addition, three Maryland counties received achievement certificates, all presented at the AMA Auxiliary meeting in Chicago in June.

Baltimore County:	For the largest per capita contribution 38 members - $67.08 per capita
Montgomery County:	For the largest contribution in the 101-200 membership category 183 members - $6,347.84
Baltimore City:	For the largest contribution in the 201-500 membership category 322 members - $9,143.91

MEDICAID MEMOS

Effective July 1, 1970, Medicaid recipients will carry a new plastic identification card. When issued, it will replace the old paper card. BE SURE TO CHECK THE EXPIRATION DATE ON ALL CARDS PRESENTED FOR SERVICE.

The time schedule for Medicaid payments is about six to eight weeks from the date the Medicaid bill is received. If patients are Medicare recipients as well, the time schedule is about ten to twelve weeks. If physicians have any substantial backlog of unpaid accounts, let the Faculty office know. Or you may write to Mrs. Florence Sokol, Provider Relations Specialist, Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore, Md. 21201, or call 383-3010, ext. 1468.

PROFESSIONAL LIABILITY INSURANCE

Not only Maryland physicians, but those in other areas as well are experiencing an increase in their professional liability insurance premiums. Latest information indicates that in Vermont and Michigan, rates increased 100%; in Ohio, 75%; in Philadelphia, 250%; in California 95% in 1968 and 110% in 1969; and in New York State, 55%.

John Sargeant
Executive Director

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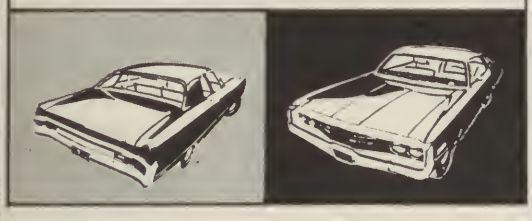
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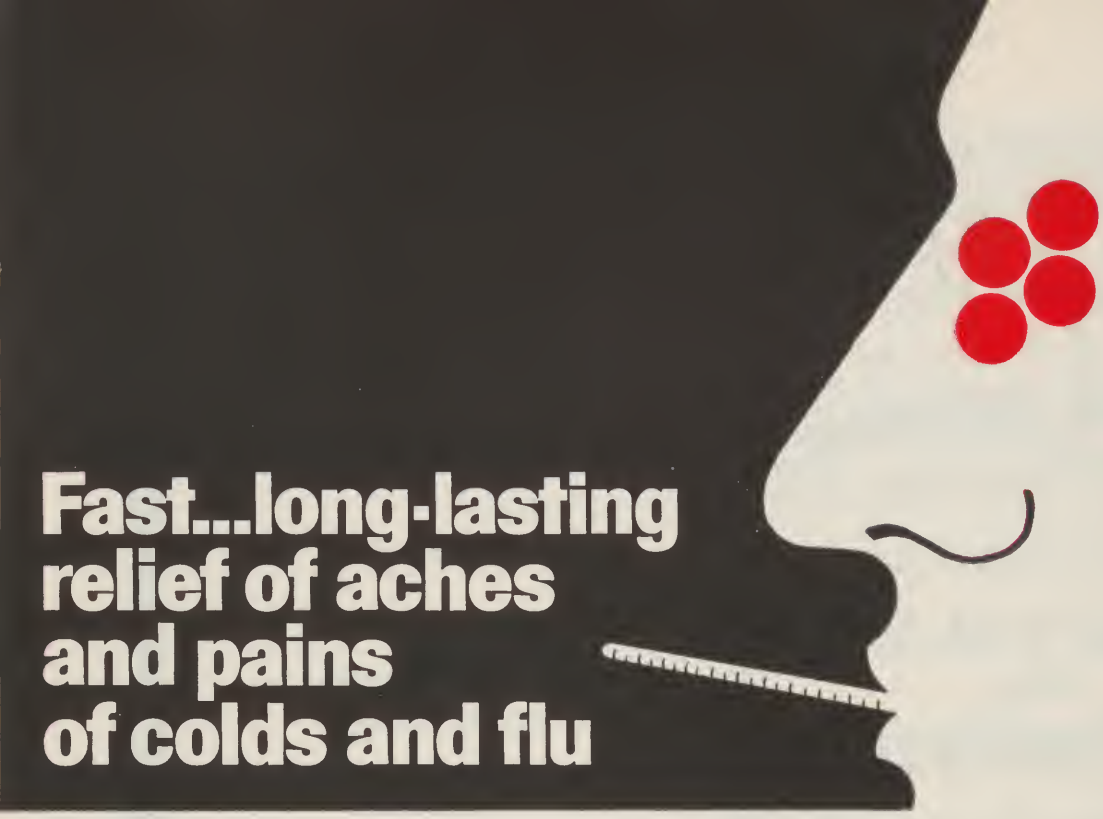
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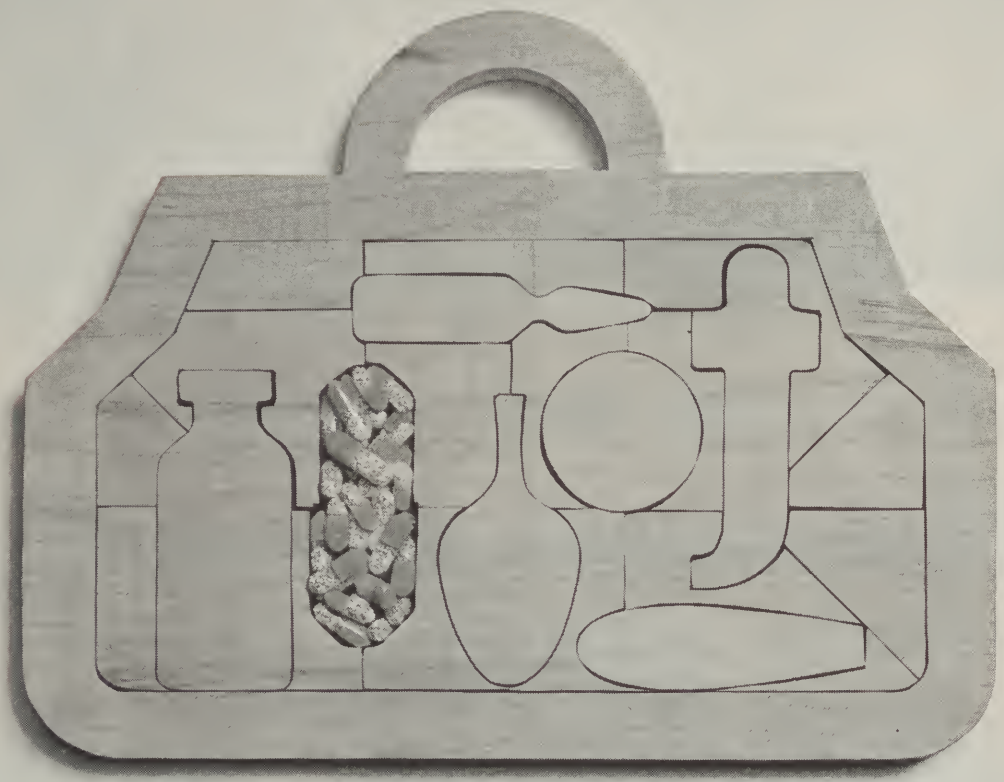
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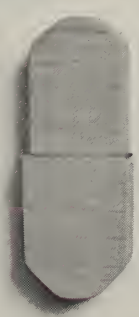
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See Clinical Considerations section on last page...

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	Resistant/ Moderately Severe	Serious/Life-Threatening
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in in dividuals with a history of hypersensitivity or toxic reactions t gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whor serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these pa tients or in those in whom recommended dosage or duration c therapy must be exceeded as a life-saving measure, routine studi of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory fun tion and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not r sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectab may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity c nephrotoxicity have not been established. Studies in pregnant an mals have not revealed teratogenic or ototoxic effects in the fetu GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisab by the physician.

Adverse Reactions: The overall incidence of ototoxicity consider related to treatment with GARAMYCIN Injectable was 2.8 per ce (16 of 565 patients). Contributory factors (two or more factors we relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently r ceived other potentially ototoxic antibiotics (streptomycin or kan mycin), and 5 were over 60 years of age. Six also had decreas high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients show increases in BUN that were probably related to treatment wi GARAMYCIN Injectable. Of 20 increases probably or possibly relat to treatment, 7 were reversible, 9 occurred in terminal patients, a 4 had no follow-up.

Other adverse reactions associated with treatment were one instar each of urticaria, decreased hematocrit, and reversible depressi of granulocytes with normal bone marrow. Other rarely report and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotensi convulsions, twitching, salivation, nausea, vomiting, increased tra aminase activity (SGOT or SGPT), increased serum bilirubin, c creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-d vials, for intramuscular administration.

For more complete prescribing details, consult package insert Physicians' Desk Reference. Schering literature is also availa from your Schering Representative or Medical Services Departme Schering Corporation, Union, New Jersey 07083.

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ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Board of Directors Meets

The Board of Directors of the Baltimore City Medical Society met on June 2, 1970 at 4:30 PM, at 1211 Cathedral Street.

The minutes of the May 5 meeting were approved as read.

C. Lee Randol, MD, presented a critique of the People's Free Medical Clinic, Inc., which is located on Greenmount Avenue. The clinic's primary aim is based on the premise that good medical care for all is a right and not a privilege. The aims of the clinic, therefore, are as follows:

1. That current health care resources can be made more accessible to a local community by:
   a. providing a focal point for evaluation of individual health needs.
   b. providing a convenient source of information on existing resources.
   c. providing assistance in utilizing those resources.
2. That primary health care can be more convenient, economical, and responsive to the particular community needs by:
   a. improving community location, administration, and operation.
   b. removing primary care from hospital outpatient departments and emergency rooms.
3. That quality of overall health care can be improved by:
   a. providing convenient facilities for primary care to encourage utilization of health care facilities at earlier stages of disease.
   b. relieving secondary and tertiary health care facilities (hospitals) of some of the burden of primary health care.
   c. providing health-related educational, counseling, and other social services in the same primary care facility.

After much discussion, the Board of Directors decided that the physicians presently in practice in the area surrounding the clinic should be contacted and questioned concerning its acceptance and approval. The Board agreed that, at face value, there seems to be no unusual, illegal, or unethical aspects in the operation of the clinic and that the idea is, in general, an excellent one, but that the organizational structure would require a more complete investigation before the sanction of the society could be offered.

The activities of the Policy and Planning Committee were reported by Philip F. Wagley, MD. The committee proposed the formation of a Baltimore City Medical Society scholarship to be awarded to a needy Negro student from Baltimore city in the amount of $1,000 a year for eight years. The selection of the recipient would be made by a Scholarship Committee, with final approval from the Board. The following factors would be taken into prime consideration when selecting a candidate:

1. Interest in medical training
2. Character traits
3. Scholastic standing
4. Citizenship and leadership
5. Financial need

The candidate should receive the recommendation of his principal and two faculty members. Each school will be requested to screen applicants and submit not more than two names to the committee.

The Board agreed that this proposal should be brought before the next general meeting of the society for consideration.

The Ad Hoc Committee to investigate the Mary-

land Artificial Kidney Treatment Fund briefly reviewed the fund's organization and operation and found several ethical problems associated with it. Further investigation is planned and the Board agreed that if the committee felt there were indeed some unethical practices, the matter should be referred to the Medical and Chirurgical Faculty Mediation Committee for consideration.

In response to a request for nominees to be considered as recipients of the Governor's Award for the promotion of the physically handicapped, the Board suggested that the names of Paul Richardson, MD, and Douglas Carroll, MD, be submitted.

The Board agreed to write to Mayor D'Alesandro offering to submit a list of names from which he might make a selection when filling medical posts in the city government.

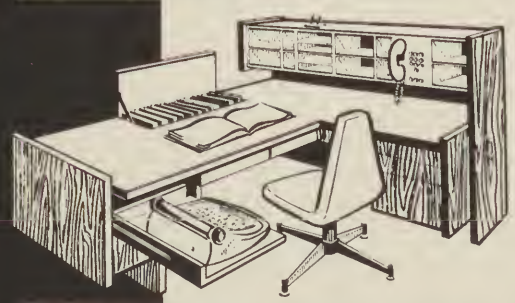
No meeting of the Board was held in July. The next scheduled meeting will be August 11.

Further discussion of the selection of a Peer Review Committee was entertained by John N. Classen, MD, and is now under advisement.

A case concerning a problem of patient-physician relationship was discussed and referred back to the Professional Relations Committee for further investigation.

The meeting was adjourned at 6:00 PM.

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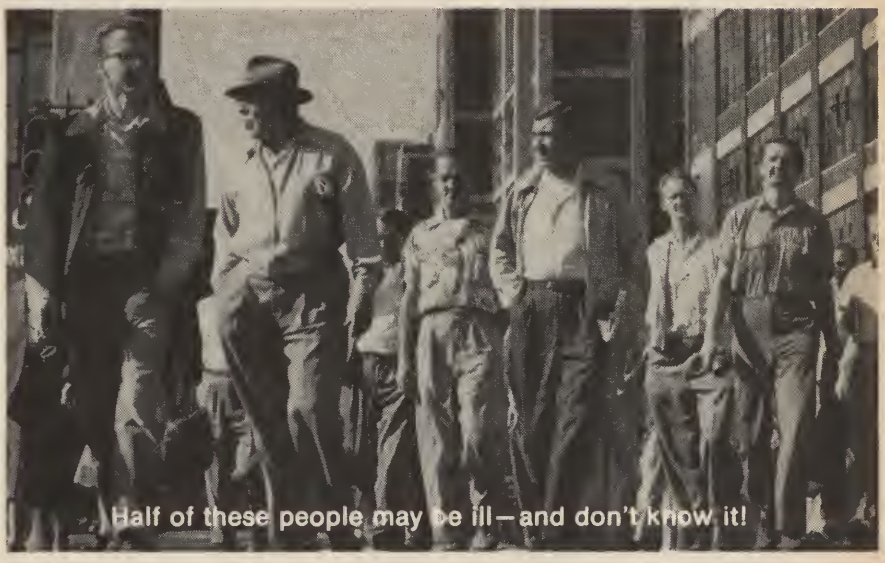
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A special staff is trained to operate the facilities and to provide efficient, low-cost delivery of accurate laboratory and physiological test results to referring physicians. A basic HSC facility of prime van and trailer is equipped for fundamental health history review and dozens of tests, including: six cardio-pulmonary, three audiometry, six opthalmologic, twelve blood chemistries, together with a hematology survey, urinalysis and 4mm chest X-ray, plus a determination of diabetes and heart trouble potential.

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Health Screening Centers, Inc., makes continuously available to investor groups the necessary technological counsel, sales guidance and legal advice. HSC will help you with initial new-business solicitations, advertising, publicity, recruitment of sales and operating personnel. At Denver headquarters, HSC will thoroughly train a staff to operate a mobile or in-plant facility. HSC will assist with all start-up procedures—in short, *everything you need to successfully operate your own health screening center.*

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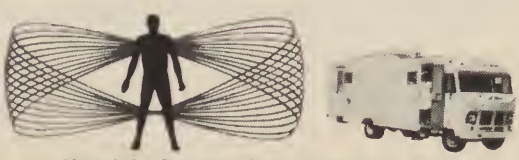
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SECOND ANNUAL GOLF TOURNAMENT

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

FRIDAY, SEPTEMBER 11, 1970 - HERSHEY, PENNSYLVANIA

WHO: Faculty members and their guests

WHEN: and WHERE: Friday, September 11, 1970

- MEN'S TOURNAMENT—Hershey Country Club—18 hole course—1:00 PM
- LADIES' TOURNAMENT—Hotel Hershey—9 hole course—1:00 PM
- MIXED TOURNAMENT—Hotel Hershey—9 hole course—2:00 PM

Tee off time is on a first come-first served basis

PRIZES: Many and valuable

COMMITTEE: Charles J. Savarese, MD, Chairman, Rockville
Austin B. Rohrbaugh, MD, Co-chairman, Bethesda
Manning W. Alden, MD, Annapolis
Andrew J. Brennan, MD, Bethesda

* * * * * *

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RESERVATION FORM—GOLF TOURNAMENTS

FRIDAY, SEPTEMBER 11, 1970

Register for ONLY ONE of the following tournaments:

MEN'S TOURNAMENT—1:00 PM—Hershey Country Club

- Assign me to a foursome ———— My handicap is —— Check is enclosed $——
- I will make up my own foursome —— My handicap is ——

Check is enclosed $——— for my registration plus the following:

———————————————— handicap ————

———————————————— handicap ————

———————————————— handicap ————

COST: Golf $6.00—Cart (required) $8.00

LADIES' TOURNAMENT—1:00 PM—Hotel Hershey

- Assign me to a foursome ———— My handicap is —— Check is enclosed $——
- I will make up my own foursome —— My handicap is ——

Check is enclosed $——— for my registration plus the following:

———————————————— handicap ————
———————————————— handicap ————
———————————————— handicap ————

COST: Golf $4.00—Cart (optional) $4.00

MIXED TOURNAMENT—2:00 PM—Hotel Hershey

- Assign me to a foursome ———— My handicap is —— Check is enclosed $——
- I will make up my own foursome —— My handicap is ——

Check is enclosed $——— for my registration plus the following:

———————————————— handicap ————
———————————————— handicap ————
———————————————— handicap ————

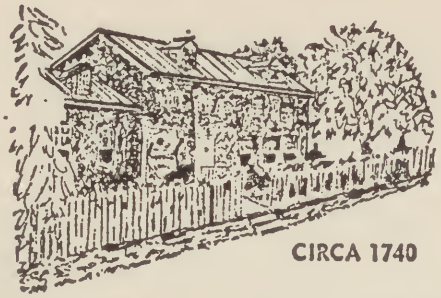
COST: Golf $4.00—Cart (optional) $4.00

NAME (please print) Address

——————————— (zip) ————

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Reservation Form

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND SEMIANNUAL MEETING - HOTEL HERSHEY

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	Staying in Hotel Hershey	Not staying in Hotel Hershey
MONTE CARLO NIGHT Thursday, September 10	No charge	No charge
GOLF TOURNAMENTS Friday, September 11	**See separate reservation form for golf tournaments**	
TOUR OF HERSHEY MEDICAL CENTER Friday, September 11	No charge	No charge
RECEPTION Friday, September 11	No charge	No charge Guests of Wicomico County Medical Society
BANQUET Friday, September 11	No charge	$8.00 per person *
MMPAC BREAKFAST Saturday, September 12	No charge	$4.00 per person *
TOURS HOTEL GARDENS Saturday, September 12	No charge	No charge
HERSHEY COMMUNITY Saturday, September 12	$2.00 per person for transportation	$2.00 per person for transportation
COCKTAIL PARTY Saturday, September 12	$5.00 per person *	$5.00 per person *
DINNER-DANCE Saturday, September 12	No charge	$8.00 per person *

CHECK IS ENCLOSED for $.....

.....
NAME (please print)

.....
ADDRESS ZIP

* Includes tip and tax

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Book Reviews

SYNOPSIS OF EAR, NOSE AND THROAT DISEASES, Robert E. Ryan, MD, Joseph H. Ogura, MD, Hugh F. Biller, MD, and Lindsay L. Pratt, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This book, like others of its kind, is primarily intended for those physicians who wish concise, yet authoritative answers to the many problems encountered in the field of otolaryngology.

It has been rewritten and revised, providing a fresh, up-to-date synopsis of all known otolaryngologic data.

A PHYSICIAN'S LIVING THOUGHTS, Carl Theneve, MD; Philosophical Library Inc., New York, New York, 1970.

This book is a compendium of one physician's thoughts on living. It is broken into various chapters or Pauses, as they are titled, such as Life, Mind, Patient and Physician, Alcohol, and Drugs.

While it contains all the various homilies that one learns over the years, it also represents the thinking of a physician who has actively practiced for more than half a century.

TRIGEMINAL NEURALGIA, Rolf Hassler, MD, and A. Earl Walker, MD; The W. B. Saunders Company, Philadelphia, Pennsylvania, 1970.

This book, co-edited by one of Maryland's distinguished physicians, represents contributions from outstanding men in their field from throughout the world. It was prepared from papers presented at a workshop held in Germany in 1967 and, accordingly, an international group of research workers is represented in its contributors.

While full review of this book would require a detailed report, it is a publication that makes an excellent reference work.

The co-editors are to be highly complimented for the succinct preparation of this material.

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☐ I HAD TO GO TO MY GRANDMOTHER'S FUNERAL. Twenty-three years ago. Then last week we had a ball splashing around the pool at Hotel Hershey.

☐ I WAS ONE OF THE SPEAKERS AT A MEDICAL CONVENTION. All I said was "Fore!", but they all listened. No place like Hershey's 72 holes for meeting AWOL medics.

☐ I WAS CALLED OUT ON A MISSION OF MERCY. My wife was dying to get away for a couple of days to Hotel Hershey, where the food is superb and she doesn't have to fix it.

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☐ I DIDN'T KNOW IT WAS LOADED. The first time I went to Hotel Hershey, that is. Loaded with all good things of life that make even a few days a luxurious vacation. But man, did I ever come back there fast, once I'd found out!

Yes, please send me your brochure.

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Baltimore County Medical Association

The June meeting of the Baltimore County Medical Association was held at St. Agnes Hospital on June 17. Greetings were extended to the members by B. Martin Middleton, MD, president of the St. Agnes staff; Emidio Bianco, MD, medical director; and Sister Teresa, administrative assistant. Wilmer K. Gallager, Jr., MD, president, presided during the business meeting. On proper motion, the application for active membership of Margaret Paxson, MD, was approved.

The speaker was Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, who spoke on "Delivery of Health Services". His presentation of the concepts developing in the delivery of health services was both timely and informative.

The members of the Association have been invited to the Timonium Race Track in August. Future plans include the annual crab feast to be held in September, the October dinner-meeting to be held at the Sparrows Point Country Club, and the November meeting, an afternoon seminar, to be held at St. Joseph Hospital.

Mrs. Dorothy E. Holman
Executive Secretary



Neil Solomon, MD, PhD (center), Secretary of Health and Mental Hygiene, confers with physicians following the June meeting of the Baltimore County Medical Association. The physicians (left to right) are: Herbert J. Levickas, BCMA secretary; Raymond Bahr, ICU-CCU director at St. Agnes Hospital; Dr. Solomon; Emidio A. Bianco, medical director at St. Agnes; and Wilmer K. Gallager, Jr., BCMA president.

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SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 12, 13, 14, 1971

Civic Center, Baltimore

As space is limited, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS

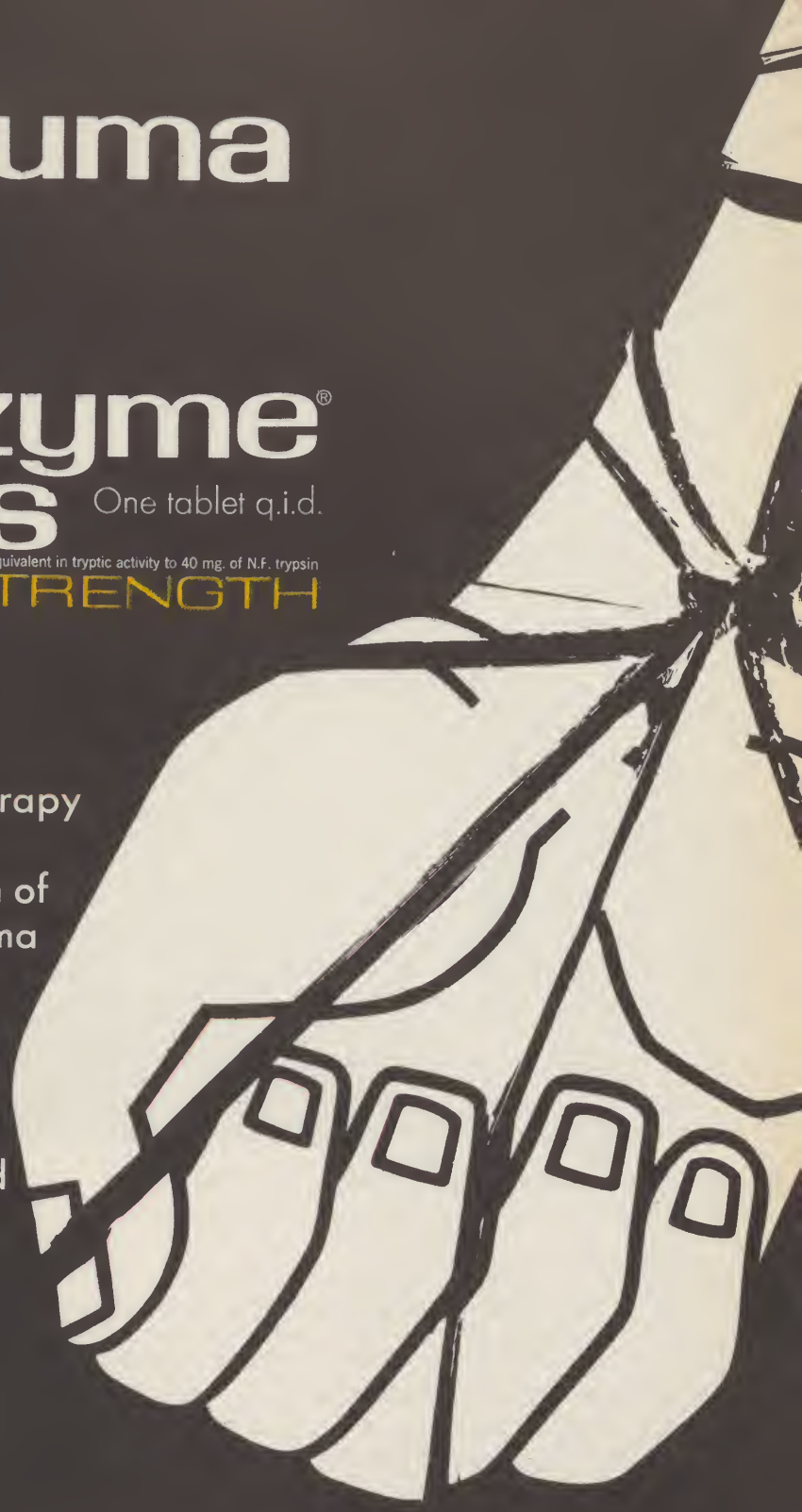
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Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., ond Lyle, J. S.: Arch. Dermot. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Voginitis ond the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Groy, L. A., ond Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., and Turkel, V.: Voginitis: A Diognostic ond Theropeutic Approoch, Scientific Exhibit, presented ot the 115th Annuol A.M.A. Convention, Chicogo, Illinois, June 1966. 10. Wolsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., ond Myers, J. E.: Pennsylvonio Med. 69:44, 1966.

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MEDICAL NEWS

Several physicians from the University of Maryland School of Medicine have been appointed assistant professors: **Virginia L. Ault, MD,** pediatrics and psychiatry; **Lindsay W. Black, MD,** biological chemistry; and **Fima N. Lifshitz, MD,** pediatrics. New clinical assistant professors are **Edward L. Sherrer, Jr., MD,** pathology; and **Ronald N. Kornblum, MD,** forensic pathology.

* * *

In February, **Emile F. Holman, MD,** was inducted as a member of The Johns Hopkins Society of Scholars. Dr. Holman is a former chief of surgery at the Pacific Medical Center in San Francisco.

The Society was created in 1967 and inducts former postdoctoral fellows at The Johns Hopkins University who have gained marked distinction in their fields.

* * *

The **Reverend Robert W. Carlson** has been elected to a two-year term as president of the **Maryland Association for Mental Health.** The Reverend Carlson is a former president of the Prince George's County Mental Health Association and rector of the Episcopal Church of the Nativity in Camp Springs.

* * *

Maurice J. Berman, MD, of Baltimore, has moved his downtown office for the practice of general surgery to 18 East Eager Street, Baltimore, Maryland 21202.

* * *

The department of medicine of St. Agnes Hospital has announced the appointment of **Joseph H. Miller, MD,** as Chief, Section of Pulmonary Medicine.

* * *

Donald S. Gann, MD, has been appointed Professor of Biomedical Engineering at The Johns Hopkins University School of Medicine. Dr. Gann has been Director of Biomedical Engineering at Case Western Reserve University School of Medicine since 1967.

His specific research and clinical interest is the control and surgery of the endocrine glands. He hopes to use computers in the care of acutely ill patients.

Dr. Gann, a native of Baltimore, received his MD degree from The Johns Hopkins University School of Medicine in 1956. The following year, he served an internship at Johns Hopkins Hospital in surgery.

* * *

The American Academy of Comprehensive Health Planning has reelected **Eugene H. Guthrie, MD,** chairman of its board of directors. Dr. Guthrie is executive director of the Maryland Comprehensive Health Planning Agency in Baltimore.

* * *

John H. Moxley, III, MD, dean of the University of Maryland School of Medicine, recently accompanied **David Clyde, MD,** professor and director of the Institute of International Medicine, to Lahore, West Pakistan for a site visit from the institute's funding agency, the Public Health Service.

* * *

William J. Hicken, MD, has been appointed Chairman of the Department of Pathology and Director of the Laboratory at St. Agnes Hospital. Sister Alberta, DC, made the announcement.

Dr. Hicken has been Associate Pathologist at St. Agnes since 1965. He will continue to serve as Assistant Professor of Pathology at the University of Maryland School of Medicine.

A native of Baltimore, Dr. Hicken received his BA degree from Loyola College and his MD degree from the University of Maryland School of Medicine. He served an internship and completed his pathology residency, both at the University of Maryland Hospital in Baltimore.



Dr. Hicken

* * *

The **Georgetown University School of Medicine** plans to increase its enrollment by 75% in less than five years. The expanded enrollment will be made possible by a project grant of over $8½ million, according to the Rev. R. J. Henle, SJ, president of the university.

The funds from the Department of Health, Education and Welfare are authorized under

the new federal Physicians Augmentation Program. It was set up to help relieve the critical health manpower shortage.

* * *

The Maryland State Department of Health and Mental Hygiene, in cooperation with the College of Engineering of the University of Maryland, held a three-day course on "Visible Emissions Evaluation", June 10-12, 1970.

The course concentrated on the latest methods of evaluating visible emissions through classroom instruction, demonstrations, and actual practice by the students. According to Jean J. Schuenuman, Chief, Division of Air Quality Control, Environmental Health Services, "This course (enabled) the students to gauge the density of smoke with reasonable accuracy and spot possible violators of air quality control regulations."

The course also stressed the legal aspects of visible emissions, including methods of gathering evidence, the taking of statements from witnesses, and how to testify at a trial.

* * *

Mrs. Jonathan Williams, of Bethesda, has been elected to serve a second term as chairman of the mental health committee of the Woman's Auxiliary to the American Medical Association. The announcement was made during the auxiliary's 47th annual convention recently held in Chicago.

Mrs. Williams has served as eastern regional mental health chairman for the auxiliary since 1964. Currently, Mrs. Williams is serving a three-year term as a member of the advisory committee to the Montgomery County Mental Health Association.

* * *

R Adams Cowley, MD, chairman of the division of thoracic and cardiovascular surgery at the University of Maryland School of Medicine, recently gave the Nuffield Lecture at the University of Oxford on "The Significance of Liver in Shock". Dr. Cowley was also appointed to the Committee on Component Therapy, Division of Medical Science, National Research Council.

* * *

A 60-minute film entitled **"Seeds of Progress"** is now available on loan from the State Department of Health and Mental Hygiene. The two reels, which can be shown separately without breaking the continuity, describe action taken by two states in tailoring special educational programs to fit the unique needs of the migrant worker. It also stresses that although their labor adds much to the economy of a community, the workers frequently do not receive any community benefits or services.

A tape-recorded interview with migratory laborers in Maryland's Dorchester County is also available, and provides an interesting supplement to the film.

Appropriate for general audiences from junior high school through adult levels, the film may be borrowed without charge in the state from the Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston St., Baltimore. Phone 383-3010, extension 8516.

* * *

Wilmer K. Gallager, Jr., MD, of Baltimore, has moved his practice to the St. Agnes Medical Center, Suite 300, 3455 Wilkens Avenue, Baltimore, Maryland 21229. Dr. Gallager's specialty is internal medicine.

* * *

The trustees of the Caleb Fiske Fund of the Rhode Island Medical Society have announced the subjects for the 1970 essay contest. The Fund sponsors the oldest medical prize essay competition in the United States. The two subjects are "The Crisis with Hallucinogenic Drugs—Possible Solutions" and "Human Cell Cultures in the Diagnosis of Disease".

A cash prize of $500 will be awarded for the best paper on either subject. Essays must be submitted by December 15, 1970. They must be typed, double spaced, and may not exceed 10,000 words.

For additional information, write: Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis St., Providence, Rhode Island 02903.

* * *

An article entitled "Masculinization of the Female Genitalia in Congenital Adrenal Hyperplasia: Relationship to the Salt Losing Variety of the Disease" was published in the June 1970 issue of the *Southern Medical Journal.* The authors are two Maryland physicians: **Barry S. Verkauf, MD,** and **Howard W. Jones, Jr., MD,** both of Baltimore.

* * *

James T. Cabler, DDS, Maryland State Dental Association president, has named six Baltimore dentists to represent the Association on several Faculty committees. **Daniel Bartell, DDS,** will be a member of the Medical Economics Committee, **Joseph P. Cappuccio, DDS,** a member of the Legislative Committee, **H. Berton McCauley, DDS,** the Library & History Committee, **William Kress, DDS,** Professional Medical Services Committee, **Harry W. Dressel, DDS,** Program & Arrangements Committee, and **Sol B. Love, DDS,** Public Relations Committee.

* * *

Ivan L. Bennett, Jr., MD,

vice-president for health affairs at New York University and director of its Medical Center since January 1969, has been appointed dean of the New York University School of Medicine and of the Postgraduate Medical School. This is the first time that the deanship of the schools and the directorship of the Center have been held by one person.

Dr. Bennett was an assistant pathologist at Johns Hopkins Hospital in Baltimore and an assistant in pathology at the university from 1949 to 1950. After holding several other positions, Dr. Bennett returned to Hopkins in 1954 as associate professor of medicine. He became full professor in 1957 and was named Baxley Professor of Pathology and director of the department the following year.

Dr. Bennett is a past president of The Johns Hopkins Medical Society.

* * *

James A. Lyon, MD, professor of radiology at the University of Maryland School of Medicine, recently presented a paper at the annual meeting of the Eastern Radiological Society in Portugal.

* * *

Miss Patricia L. Kienker has been awarded first place for her scientific essay entitled "Cardiac Pacemakers". A junior student at St. Agnes Hospital's School of Radiologic Technology, Miss Kienker received the award at the 11th annual state meeting of the Maryland Society of Radiologic Technologists held in Gaithersburg.

Miss Kienker competed against radiology students from other approved AMA schools in the Maryland region.

* * *

Results of the first certifying examination in the new medical specialty of family practice are in. Of the 2,078 physicians who took the exam, 81.6% passed it successfully. The exam was offered nationally on February 28-March 1, 1970.

A second examination will be given in February 1971. Those physicians who pass will be included in the charter membership group of the Board of Family Practice.

* * *

In February 1970, the **Wilmer Clinic** of **The Johns Hopkins Hospital** conducted a full day of mass screening for eye problems, with special emphasis on histoplasmosis. Participating in the study were most of the Wilmer resident staff, many full-time physicians, 32 volunteer nurses, several physicians from the School of Hygiene and Public Health, and 150 volunteers from the Walkersville Lions Club and community. The ophthalmology and epidemiology teams screened 1,200 people from Walkersville—70% of the town's population.

Each person tested received a skin sensitivity test and a routine eye examination. According to Ron Smith, a member of the Wilmer house staff, "We wanted to determine the incidence of histoplasmosis of the eye in an isolated population where the disease is known to occur."

Results of the screening tests will be keypunched for computer analysis. When the analysis is completed, ophthalmologists will have more information about the relationship between histoplasmosis and eye disease.

* * *

The Passano Foundation, Inc. recently announced **Paul C. Zamecnik, MD,** of Boston, Massachusetts, as the 1970 recipient of the $7,500 Passano Award. Dr. Zamecnik received the award, one of the highest in American medicine, for his investigations that opened the process of protein synthesis to direct study, a chemical process in both normal and tumor or cancer cells.

The Passano Award is sustained by annual contributions from the Williams & Wilkins Company, publishers, and Waverly Press, Inc., printers, of Baltimore.

* * *

Marion Friedman, MD, and **Harry L. Knipp, MD,** both of Baltimore, have been certified by the American Board of Family Practice in the new medical specialty of family practice.

* * *

Russell R. Monroe, MD, professor of psychiatry at the University of Maryland School of Medicine, has been named president-elect of the Maryland Psychiatric Society.

* * *

Caroline Bedell Thomas, MD, has been promoted to Professor of Medicine at The Johns Hopkins University School of Medicine.

Dr. Thomas has been with the Hopkins Hospital staff since 1935. She started the adult cardiac clinic and became its first physician-in-charge. Her research has included studies on high blood pressure and the use of drugs in preventing rheumatic fever. Since 1946, Dr. Thomas has been director of the study of the precursors of hypertension and coronary disease.

* * *

Lutheran Hospital has received the certificate of accreditation for two years by the Joint Commission on Accreditation of Hospitals.

The joint commission is composed of the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association.

Hospitals participate in the accreditation program on a voluntary basis.

* * *

The *Johns Hopkins Medical Journal* has ceased publication. The journal, founded in 1889, fell victim to tight money and competition.

* * *

Richard E. Hoover, MD, Baltimore ophthalmologist, was recently elected to membership on the National Society for the Prevention of Blindness' board of directors. Dr. Hoover, Assistant Professor of Ophthalmology at The Johns Hopkins University School of Medicine, is also chairman of the society's Committee on Low Vision Aids.

* * *

Neil Solomon, MD, PhD, has been appointed to the Advisory Council on Drug Abuse. The appointment was made by Governor Mandel.

* * *

Now available from the American Cancer Society is a free pamphlet for physicians explaining the technique of breast self-examination for their patients. According to figures computed by the society, 1,300 new cases of breast cancer are expected this year in the state.

For information on obtaining a limited supply of the pamphlets, contact your local unit of the American Cancer Society.

* * *

Joseph S. Redding, MD, former anesthesiologist-in-chief at Baltimore City Hospitals, is now associated with the University of Nebraska Medical Center as Professor of Surgery (anesthesiology).

* * *

Several Maryland physicians recently participated in the 1970 meeting of the University of Maryland Surgical Society. Participants included **John H. Moxley, III, MD,** Dean of the University of Maryland School of Medicine, **Robert W. Buxton, MD, Marvin Cornblath, MD, Arthur L. Haskins, MD, Theodore W. Woodward, MD,** and **George H. Yeager, MD.** Participating in the scientific sessions, with **James G. Arnold, MD,** as moderator, were **Edward W. Campbell, MD, David S. McHold, MD, Raymond M. Cunningham, MD, Harry C. Hull, MD,** and **Neil A. Robinson, MD.** Sessions moderated by **William B. Long, MD,** included **Sufah Attar, MD, R Adams Cowley, MD, Philip J. Ferris, MD, Robert M. N. Crosby, MD,** and **Arlie R. Mansberger, Jr., MD.**

* * *

The recipient of the first annual Alexander J. Schaffer Award for excellence in clinical teaching is **William H. Zinkham, MD,** of Baltimore. Dr. Zinkham, a 1947 graduate of The Johns Hopkins University School of Medicine, is presently Associate Professor of Pediatrics at The Johns Hopkins Children's Center.

The award is named for **Alexander J. Schaffer, MD,** Associate Professor Emeritus of Pediatrics at Hopkins. Dr. Schaffer, who has been associated with Hopkins for over 40 years, was Director of The Johns Hopkins Community Pediatrics Program.

The award was originated by the department of pediatrics house staff at the Children's Medical and Surgical Center.

* * *

Marcus W. Moore, Sr., MD, of Baltimore, was recently reappointed by Governor Mandel to the Advisory Council on Hospital Construction, and will serve a three-year term.

A new appointment to the Air Quality Advisory Council, to fill the remainder of a five-year term from June 1, 1967, is **Henry Koellein, Jr.,** of Baltimore. Reappointed to the Council are **Donald W. Pritchard, MD,** of Severna Park, and **John G. Lentz, MD,** of Columbia.

Appointed to serve five-year terms on the Advisory Board on Hospital Licensing are **Paul O. Becker** and **Victor H. Morgenroth, Jr.,** both of Baltimore.

Arthur E. Cocco, MD, of Baltimore, has been appointed to serve the remainder of a one-year term on the Board of Examiners of Nursing Home Administrators.

Reappointed to the Maryland Commission on Medical Discipline, **Elmer G. Linhardt, MD,** of Annapolis, will serve a three-year term.

Russell H. Morgan, MD, of Baltimore, has been reappointed for a four-year term on the Radiation Control Advisory Board.

* * *

Edmund G. Beacham, MD, has been elected president of the Baltimore Area Council on Alcoholism. **Harry F. Klinefelter, MD,** was elected to share the office of vice-president with **Robert Hammen.**

Among the new members elected to the Advisory Board are **Robert E. Farber, MD,** and **Addison W. Pope, MD.**

* * *

Some "do's" and "don'ts" for lifeguards are illustrated in **"No Second Chance",** a 20-minute color film available from the State Department of Health and Mental Hygiene.

In the film, lifeguards at public and private swimming pools are urged to learn mouth-to-mouth and mouth-to-nose methods of resuscitation, and learn to recognize dangerous situations before they develop into tragic accidents. The film also includes other suggested preventive measures, and important safety reminders for pool managers and owners.

Recommended especially for training lifeguards and camp counselors, the film may be borrowed without charge from the Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston St., Baltimore. Phone 383-3010, ext. 8516.

* * *

Raymond A. Sjodin, MD, professor of biophysics at the University of Maryland School of Medicine, served as local arrangements chairman for the annual Biophysical Society, which met in Baltimore in February.

* * *

Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, in an address to a bipartisan group of congressional wives and staff members, recently discussed a proposal for a **National Health Insurance Program.**

According to Dr. Solomon, this would be a voluntary health payment program and would allow both patient and physician the right of choice of participation. For those who participate in the program, he envisions payment for total health care, including hospitalization. He likened this plan to the guarantee of universal free education for all Americans.

* * *

W. Hamilton Whiteford has been elected president of **Hospital Cost Analysis Service, Inc.** The service is an independent, nonprofit agency that studies and evaluates hospital costs in Maryland.

A member of the board at Maryland General Hospital, Mr. Whiteford succeeds Dr. Albin O. Kuhn.

* * *

James A. Dorsey has been appointed executive assistant to **Neil Solomon, MD, PhD,** Secretary of Health and Mental Hygiene. Mr. Dorsey will act as liaison officer to the executive staff of the department and all agencies within the department.

Mr. Dorsey was previously associated with Sinai Hospital as an administrative staff member.

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Salvatore Raiti, MD, has been appointed associate professor of pediatrics at the University of Maryland School of Medicine. **Lois A. Young, MD,** has been named associate professor of ophthalmology.

* * *

Two Maryland men, **Seymour Leon,** and **Robert W. Gibson, MD,** recently received the highest national public relations award—**The Silver Anvil.** Governor Mandel made the presentation.

Mr. Leon is Director of Community Relations & Development, and Dr. Gibson is Medical Director at the Sheppard and Enoch Pratt Hospital in Towson. The hospital is only the second Maryland winner in the 26-year history of the award.

* * *



Seymour Leon (left) and Robert W. Gibson, MD (middle), receive the Silver Anvil public relations award from Governor Mandel. Mr. Leon is Director of Community Relations and Development, and Dr. Gibson is Medical Director at Sheppard and Enoch Pratt Hospital in Towson.

A new "crisis clinic" for the emergency treatment of the mentally ill has been established at **Sheppard and Enoch Pratt Hospital** in Towson. The clinic will examine and treat persons who attempt suicide, those with acute schizophrenia, and any other severely disturbed persons in the northern Baltimore County area.

Samuel Blumenfeld, MD, clinic director, expects 40 to 50 patients a week. Staffed by 15 psychiatric residents and a full-time social worker, the clinic will offer patients daily short-term consultation and such services as vocational and marital counseling.

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Herbert B. Copeland, MD, Nathan B. Hyman, MD, Albert B. Shackman, MD, Nathan Stofberg, MD, Martin J. Birnbaum, MD, and **Larry A. Snyder, MD,** have announced the association of **Samuel Andelman, MD,** in the private practice of diagnostic radiology.

* * *

Appointed instructor at the University of Maryland School of Medicine are **Henry I. Babitt, MD,** medicine; **Earl Clayton Davis, Jr., MD,** otolaryngology; **Robert F. DeBusk, MD,** medicine; **Rose Marlene Gieske,** nursing in neurology; **Ronald E. Gillilan, MD,** medicine; **Michael Gospe, MD,** medicine; **John Hammann, MD,** medicine; **Karl E. Hammermeister, MD,** medicine; **Robert A. Hartley, MD,** medicine; **Vilis E. Kilpe, MD,** medicine; **Noel D. List, MD,** epidemiology; **Prasarn Nilprabhassorn, MD,** radiology; and **Linda L. Wadian,** nursing in neurology.

* * *

Maureen Henderson, MD, of Baltimore, has received a grant from the Research Project Fund of the Southern Medical Association. Professor of Preventive Medicine at the University of Maryland School of Medicine, Dr. Henderson received the grant for her research project on the epidemiologic study of mongolism.

* * *

An article on breast cancer treatment by a Baltimore physician, **T. Brannon Hubbard, Jr., MD,** appears in the May 18 issue of *Modern Medicine.* The article is entitled "Should biopsy of the 'normal' breast be done in the patient with proved unilateral breast cancer?"

Dr. Hubbard is associate professor of surgery at the University of Maryland School of Medicine.

* * *

Joseph F. McManus, Executive Director of the Federation of American Societies for Experimental Biology in Bethesda, has been named visiting professor of pathology at the University of Alabama Medical Center. Dr. McManus, former chairman of the UA Medical Center's department of pathology, is an international authority on histochemistry and its application to renal disease.

* * *

John E. Adams, MD, has been appointed Associate Director of the Division of Manpower and Training Programs of the National Institute of Mental Health.

According to Stanley F. Yolles, MD, Director of the Institute, Dr. Adams will head its program planning and evaluation functions.

* * *

The Ritchie Unit of the Rosewood State Hospital, a new facility renovated to accommodate the mentally retarded, was recently opened on the grounds of the Mt. Wilson State Hospital in Pikesville. Formerly used by persons with respiratory diseases, the Ritchie Building has a capacity for 100 patients.

* * *

James E. Carson, MD, Commissioner of Mental Hygiene, has announced the initiation of a program to correct a long-standing problem in care and treatment of Baltimore city's mentally ill. The new program provides improved transportation of patients in the city to Spring Grove, Crownsville, and Springfield State Hospitals. It also offers an appropriate health setting for transportation of the ill, with an alcoholism counselor or a psychiatrically trained nurse in attendance.

* * *

The National Society for the Prevention of Blindness will allocate a substantial portion of its research funds to provide prompt support to promising investors who have not received extensive financial support for research in the past. Acceptable projects are those which may contribute to basic understanding of eye function and disease, or that may improve diagnosis and treatment, or that may be directed toward the prevention of an eye disease.

Grants are made for a one-year period. The maximum period of support for research is two years. Application forms and further information may be obtained by writing to the Committee on Basic and Clinical Research, National Society for the Prevention of Blindness, Inc., 79 Madison Avenue, New York, New York 10016.

* * *

Simon H. deBruin, MD, has been named research associate in biochemistry and **David Blake, MD,** a research associate in anesthesiology at the University of Maryland School of Medicine.

* * *



THE MONTH IN WASHINGTON

An American Medical Association proposal for peer review for the medicare and medicaid programs drew favorable reactions from members of the Senate Finance Committee.

Peer review was one part of a three-point program which Gerald D. Dorman, MD, the outgoing president of the AMA, offered in testimony at a Senate Finance Committee hearing on medicare and medicaid.

Dr. Dorman and Dr. Julius W. Hill, president of the National Medical Association, testified together. They jointly urged Congress, on behalf of their organizations, to replace medicaid with a national health insurance program subsidized by the federal government.

The AMA health insurance proposal, which was initially approved by the AMA House of Delegates in 1968, is similar to the plan President Nixon included recently in his proposed revised new national welfare program. He said he would send such legislation to Congress early next year.

Congress is not expected to take up proposals for national health insurance this year. But reaction to the peer review proposal was highly encouraging, and prospects for Congressional approval this year appear good. Sen. Wallace F. Bennett (R., Utah), a finance committee member, directed the committee's staff to work with AMA staff representatives in drafting such legislation as an amendment to a bill revising medicare and medicaid.

The president of the AMA, with 223,000 members, and the predominantly Negro NMA, gave assurances at the finance committee hearing of the medical profession's cooperation in solving the nation's health care problems. It was the first time that spokesmen for the two leading medical associations had testified together before a Congressional committee.

According to Dr. Dorman, "the medical profession hopes to see the nation pursue" the three-point program in efforts to provide quality health care for everyone as economically as possible.

Dr. Hill said the insurance plan would work better than medicaid in the ghettos. He also defended physicians against accusations that they have been profiteering under medicaid and medicare.

The first two parts of the AMA program comprised the association's "medicredit" health insurance plan. The third, peer review, "is a way to assure both scientific quality and economic reasonableness in the medical and health care people get," Dr. Dorman said.

"Our first program would meet the problems of the Title XIX medicaid program," Dr. Dorman said. "Under our plan, each low income person or family would receive a certificate for the purchase of a qualified and comprehensive health insurance plan. The protection would be theirs without expense or contribution since the cost of the program would be borne entirely by the federal government.

"The second offers tax credits on a sliding scale based on the tax liability of a family, for the purchase of qualified health benefits coverage. For those with moderate or higher incomes, the program would provide cash incentives through income tax credits to encourage them to protect themselves against major health care costs.

"The third part of our program calls for a structured peer review mechanism to insure high quality of care and to prevent abuses of the medicare and medicaid programs."

Dr. Dorman noted that the committee's staff, in a report last February on medicare-medicaid, suggested that organized medicine regulate itself.

"We agree, and propose a program providing for professional review of matters bearing on reasonableness of charges for, need for, and the quality of services rendered by, the provider of medical or other health services," he said.

In a speech before the Senate, Bennett said there is deep concern over the high costs of medicare and medicaid. He compli-

mented the AMA on advancing peer review as a means of curbing these costs. He said:

"I believe the American people are justifiably concerned over the tremendous costs of health care. Much of that concern, it seems to me, is a product of a very real feeling that we are not getting what we are paying for. I believe, equally, that much of the apprehension, anxiety, and suspicion now prevalent—for better or worse—with respect to those responsible for health care would disappear if professional standards review organizations were established and functioned effectively. It seems to me that the American people are entitled to know that American medicine shares their concern—and more importantly—proposes to do something substantial about it through means of professional standards review organizations . . .

"I believe that physicians, properly organized and with a proper mandate, are capable of conducting an ongoing effective review program which would eliminate much of the present criticism of the profession and help enhance their stature as honorable men in an honorable vocation willing to undertake necessary and broad responsibility for overseeing professional functions. If medicine accepts this role and fulfills its responsibility, then the government would not need to devote its energies and resources to this area of concern. Make no mistake: The direction of the House-passed social security bill is toward more—not less—review of the need for, and quality of, health care. I believe my amendment would provide the necessary means by which organized medicine could assume responsibility for that review."

Bennett said that under his amendment review groups would have responsibility for reviewing "the totality of care provided patients—including all institutional care". That responsibility, he said, would be lodged "wherever possible and wherever feasible", at the local community level. He said:

"Local emphasis is necessary because the practice of medicine may vary, within reasonable limits, from area to area, and local review assures greater familiarity with the physicians involved and ready access to necessary data. Priority should be given to arrangements with local medical societies—of suitable size—which are willing and capable of undertaking comprehensive professional standards review . . .

"Under the amendment, the Secretary (of Health, Education and Welfare) could use state or local health departments or employ other suitable means of undertaking professional standards review only where the medical societies were unwilling or unable to do the necessary work, or where their efforts were only pro forma or token. Let me emphasize as strongly as possible that the thrust of this proposal is to have physicians, as a group, evaluate physicians and the services they provide and order as individuals."

Bennett said that the review committees should determine that only medically necessary services are provided by physicians, hospitals, nursing homes and pharmacies, and that these services meet proper professional standards.

Disciplinary measures, he said, would be in proportion to the offense and could include: 1) monetary penalties, 2) suspension from federal programs, 3) exclusion from federal programs, 4) civil or criminal prosecution, and 5) steps leading to the suspension or revocation of professional licensure.

Dr. Hill directed his testimony before the finance committee mainly to medical care of Negroes and other poor people, particularly in ghettos. He took issue with the committee staff report which, he said, "by implication attacked the very physicians working closest to the poor and treating them". He said restrictions on physicians' fees, as advocated in the report, would make more acute the already critical shortage of physicians in ghettos.

"To those who read the entire report, there were a number of very complimentary things said about all physicians," Dr. Hill said. "But the primary message, the one seized upon by the press and broadcast across the country, appeared to be that any doctor earning a substantial amount of money from medicare-medicaid was somehow cheating both the government and his patients.

"It was bitterly ironic. To work 60 and more hours a week in the ghetto, and to be fairly paid, was suddenly prima facie evidence of wrongdoing.

"The report was also interpreted so that the blame for the rising cost of medicare-medicaid was directed at the physician—and particularly those caring for the poor.

"Therefore, we of the National Medical Association take strong exception. The implications and accusations of that report were grossly unfair. It is difficult enough to get physicians to practice among the poor . . . If these men, professionals committed to providing care, are to be subjected to irresponsible accusations for the size and success of their ghetto practices, it will very soon be impossible to find a doctor among the American poor."

The associations showed the senators a brief movie of physicians practicing in a Chicago ghetto health center and in an Appalachian community clinic.

* * *



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Beef	8.0	Hot Dog Bean	8.4
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Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

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Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
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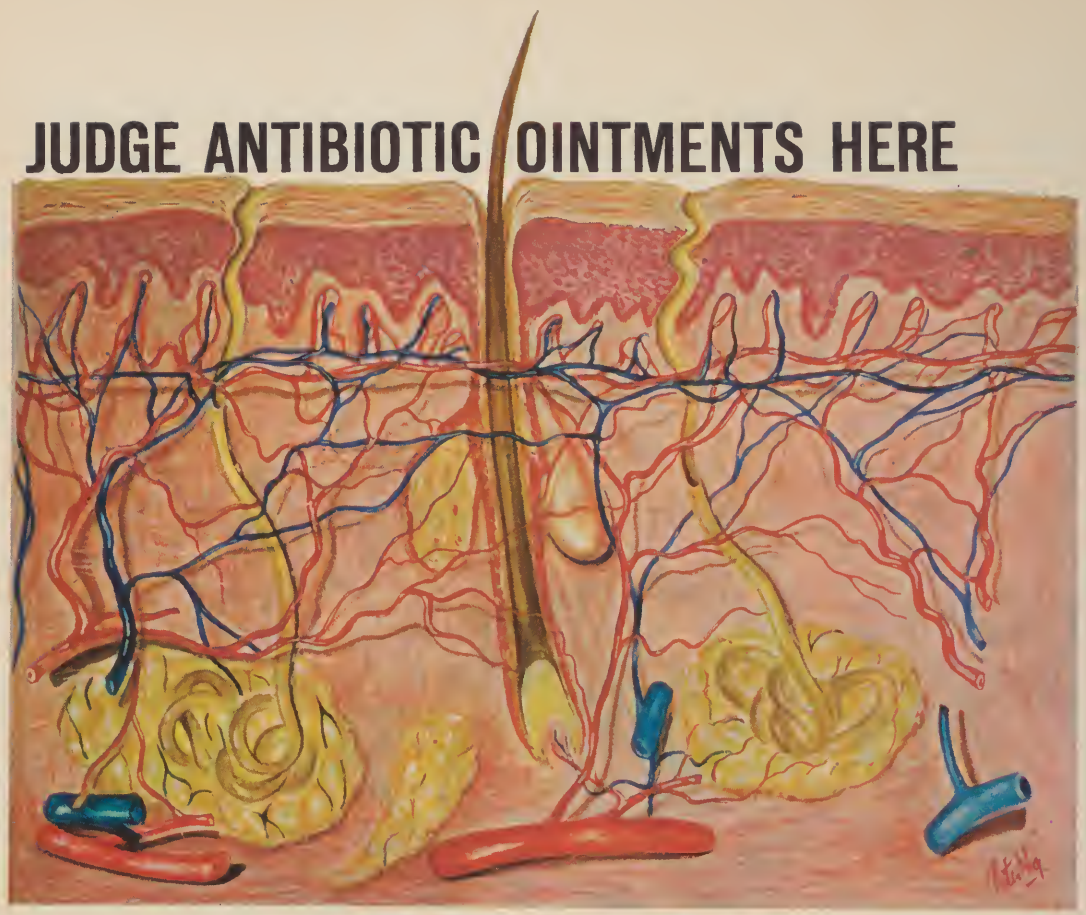
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MRS. ROBERT W. GARIS, EDITOR

Ladies Activities for the Semiannual Meeting

The Faculty's Program and Planning Committee has met twice since April. In addition, I have journeyed to Hershey, Pennsylvania to help make arrangements for the Semiannual Meeting on September 10, 11, and 12, 1970. The members of the committee are Doctors Arlie R. Mansberger, Jr. (chairman), John B. DeHoff, William L. Stewart, Albert M. Antlitz, Henry A. Briele, Mrs. Genevieve Ritchie from the Faculty staff, and myself.

My responsibility to the committee is centered around planning activities for the ladies and helping with the social functions. We are fortunate, as doctors' wives, to be included in a portion of our husbands' schedule, and our own plans will revolve around their activities and will include everyone.

Thursday evening will be Monte Carlo Night again this year. This event was enjoyed by many last year and is included this year by request.

Friday promises to be a full day. Our Semiannual Meeting is scheduled to start with registration at 9:00 AM, followed by the business meeting at 9:30 AM.

At this point, I want to emphasize that our auxiliary is only as strong as the weakest member. The business of the auxiliary is the business of all doctors' wives because it concerns our husbands and their colleagues. The only way we can grow and continue to contribute to community programs is through the continued support of the individual wife and the encouragement of the component medical societies. We are essentially a service organization dedicated to volunteer work and promotion of fellowship between physician families. Plan to attend our meeting and see where the action is—and where it could be!

Following our meeting, we have been invited to join our husbands for the scientific program at 11:00 AM. Plans are still incomplete as of this writing. The program promises to be an interesting and timely panel discussion on ecology of the Chesapeake Bay and marshes, and pollution. Anyone interested in hunting, fishing, and water sports will find this program especially informative.

The M.P.A.C. Luncheon is scheduled for 12:30 PM. Since this is an election year, the speaker should have some informative political remarks to make.

Those interested in golf will have to forego the luncheon since tee off time is scheduled for 1:00 PM, with mixed foursomes to start at 2:00 PM. In order to have everything go smoothly, the ladies and the mixed foursomes will play the nine-hole course at the hotel. This will enable everyone to return to the hotel in time to relax and get ready for the cocktail party, to be followed by dinner and entertainment by the well-known entertainer, Mark Russell.

Also scheduled for Friday afternoon is a tour of the Hershey Medical Center. This is being repeated by request and will include a tour of the hospital portion of the center, which was still under construction last year.

Those interested in a conducted tour of the rose gardens at the hotel will get together on Saturday morning. In the event of rain, another program will be substituted. The manager of the hotel is hoping to include a look at the Hershey Boys School as part of the tour of Hershey and the Hershey Museum scheduled for Saturday afternoon. We might also get to visit one of the dormitory units located on the farms of Hershey that house the students of the school.

Saturday evening will start with a cocktail party and will be followed by a dinner-dance. The auxiliary has been asked to provide entertainment again, and Mrs. Richard Bauer is in charge of the intermission show. Talent will be drawn from our own ranks and the outlook promises another fun evening again this year.

If anyone is interested in tournament bridge, let us know when you register. A tennis tournament is not practical because of the limited facilities. If you like, however, bring your own racket and play for fun.

A different feature this year is the hobby corner,

to be located in the lobby hall behind the Med-Chi registration desk. If you have a hobby, please bring a sample for display. It will be interesting to see the various hobbies enjoyed by the doctors and their wives. This could be a springboard for new friendships through mutual spare time endeavors. This is for husbands *and* wives—don't be bashful! Let's all join in the hobby fun and compare notes. Help make this the biggest, best, and most fun Semi-annual Meeting ever! See you there.

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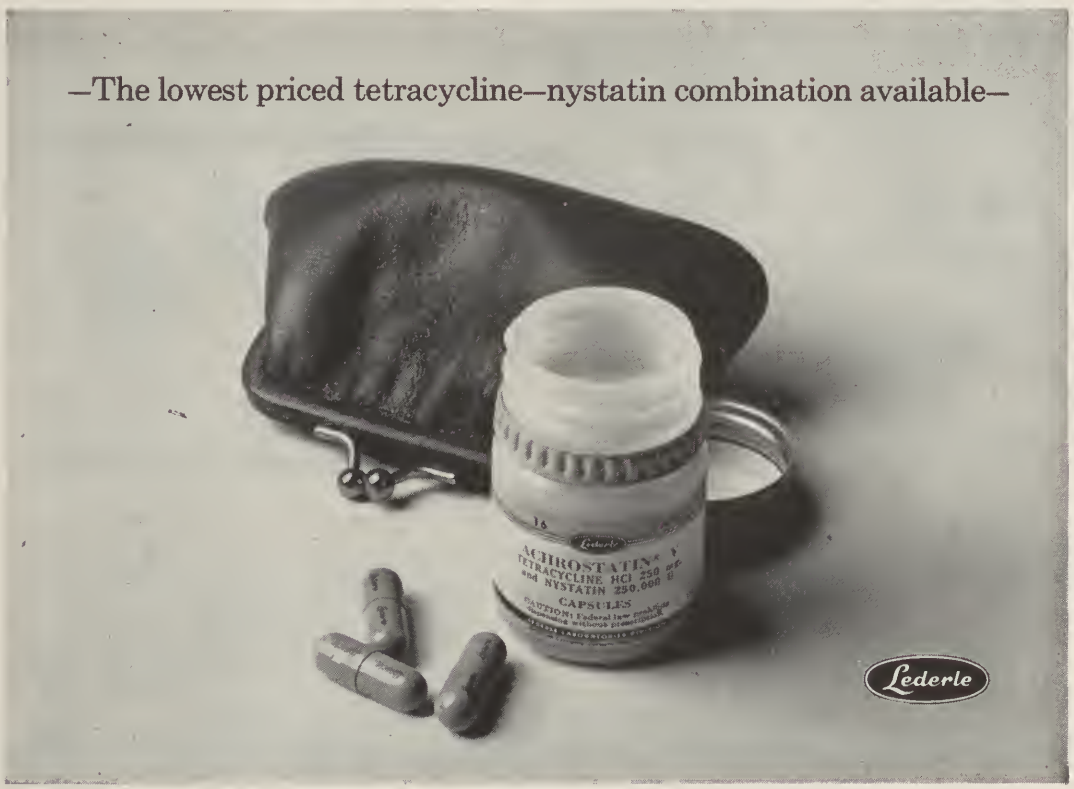


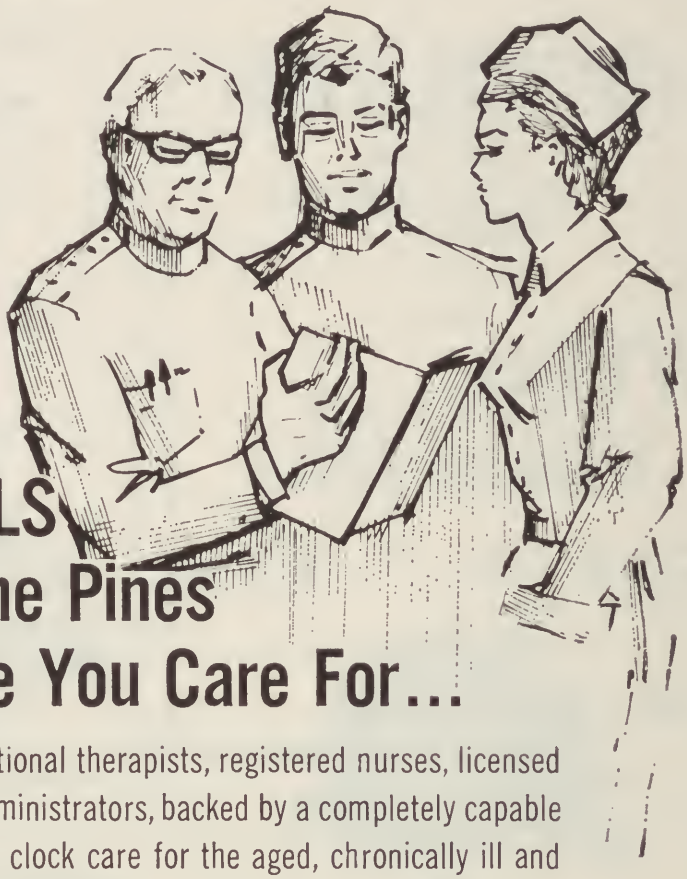
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Letters to the Editor

Controversy over Semantics

Dear Sir:

As the Director of the Maryland Poison Information Center, and a member of the Medical and Chirurgical Faculty of Maryland, I had occasion to review the May 1970 *Maryland State Medical Journal.* The summary of reported poisonings in Baltimore City 1967-1968 was rather impressive in that it noted the city had 3,775 poisonings in 1968. [Reported by the Baltimore City Health Department on page 101.] Since we keep statistics not only for the city, but all of Maryland, I want to note that in general these reports were not poisonings, but only ingestions. (Ingestion includes all products that have been taken orally, and were either not intended for internal use—household products, plants, etc.—or not intended for use for the individual who had taken them, and that these products were taken in sub-toxic amounts.

I feel that I should point this out since stating information to the medical profession which is known to be faulty may be questioned.

Mary S. Furth, MD, Director
Maryland Poison Information Center
Baltimore City Hospitals

Dear Sir:

Thank you for your note regarding the poison statistics reported in the May issue.

The figures which were used in the report are derived from a poison ledger system developed in 1967 through the joint efforts of the City Health Department's Bureau of Food Control and Dr. Emily Seidel, Director of the Maryland Poison Information Center, which is now under the supervision of Dr. Furth. This was the first system and the first real attempt to get statistical information about the important area of poisonings. Each hospital or clinic was visited individually and asked to report all instances of patients reporting to the emergency room as a poisoning. The information was indicated on a form prepared jointly by the Health Department and the Poison Information Center. These are the figures which have been used since this new program was started.

As I understand it, Dr. Furth is concerned about not using the word "ingestion". However, the hospitals were asked to report cases of "poisonings". The poison reporting ledger system is still being maintained in its present state since it does provide useful information on poisonings. No doubt the Maryland Poison Prevention Committee will eventually come up with a satisfactory solution that will be agreeable to all its members.

We are all deeply committed to preventive medicine and this information is a useful tool.

Joseph Gordon, Director
Bureau of Health Information
Baltimore City Health Department

* * *

A Psychiatrist Speaks Out

Dear Sir:

The lesson to be learned from the recent Wayne Young case in Baltimore was clearly stated in the turbulent trial of Jack Ruby. It is that the psychiatrists do not belong in the courtroom in such cases. Four qualified psychiatrists found the defendant to be "insane" and four others, as equally qualified, declared the same individual to be "sane". It has long been acknowledged that with a "battle of the experts" the question of "sanity" becomes an impossible issue.

The jury should not be made responsible for deciding the defendant's mental state at the time of the criminal act. All that a jury can competently answer is whether the defendant has committed the criminal act as charged.

Whenever the question of mental competence to stand trial arises, the court can arrange for a panel of experts to determine the defendant's *present* mental status. Does he understand the nature of the charge, and is he mentally competent to participate in his own defense? If the defendant is found guilty, the same panel can advise the judge on an out of court basis in regard to the effectiveness of treatment. Psychiatrists should refuse to testify in court in regard to what was in the defendant's "mind" at the time of the offense. Also, "Insanity" as a defense is too complex and too technical for a jury to determine. Only when psychiatrists are barred from the courtroom, or refuse to testify except on an out of court basis, can the perplexing problems involved in the evaluation of the insanity plea be effectively solved.

Jacob H. Conn, MD
Former Acting Chief Medical Officer to the Supreme Bench of Baltimore

* * *

A Message Well Presented

Dear Sir:

Congratulations on an excellent Traffic Safety

Issue (May 1970). You deserve full credit for pulling together enough material to make an effective presentation, well presented and well arranged. Many thanks from me, Dr. Baldwin and the other members of the Committee on Traffic Safety.

Timothy D. Baker, MD, Chairman
Traffic Safety Committee
Professor
Department of International Health
The Johns Hopkins University
School of Hygiene and Public Health

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Frederick County Medical Society

Ernest A. Dettbarn, MD
Journal Representative

"Because of his enthusiasm and steadfast efforts, a blood donor program was established in Frederick County in conjunction with the Red Cross . . ."

James A. Grove, former Frederick postmaster, was presented the society's "Appreciation Award" at a dinner-meeting in May. The certificate, sponsored by the Medical and Chirurgical Faculty, was presented by the society president, A. M. Powell, Jr., MD.

Mr. Grove, who served as postmaster from 1950 until 1968, was chairman of the American Legion blood program from 1946 to 1961, and served as chairman of the county Easter Seal fund drive in 1960 and 1961. Through his inspiration, leadership, and devotion to his volunteer work, a countywide blood bank program was established in conjunction with the Red Cross in 1961. Mr. Grove has served as chairman since its inception.

In presenting the award, Dr. Powell expressed not only the gratitude of the members and their wives and guests present, but also of all citizens who have personally benefited from the services of the blood bank. Tribute was also given to Mrs. Grove for her patience and understanding during the many hours given by her husband in volunteer services.

"The Third Parent" was the topic of the guest speaker for the evening. Duncan Wallace, MD, child psychiatrist in the Washington, D.C. area, gave an enlightening and most informative talk on the effects of television (the third parent) on children. Citing alarming statistics, he discussed the impact of violence on the lives of children who are exposed to television violence for more hours than they are in the school classroom. His comments were most thought-provoking for all present.



A.M. Powell, MD (left), president of the Frederick County Medical Society, presents the certificate of appreciation to Mr. James A. Grove for his efforts in the county's Blood Bank program.

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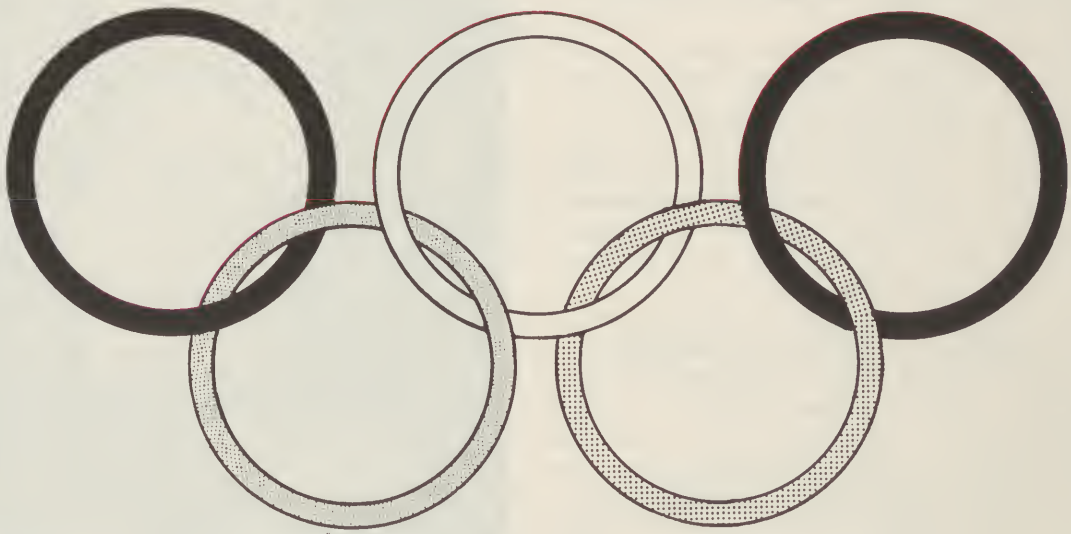
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The following papers were presented at the Third Annual Medical Aspects of Sports Seminar held in December 1969 at Catonsville Community College in Catonsville, Maryland. The Seminar was sponsored by the Medical and Chirurgical Faculty of the State of Maryland and the Division of Health, Physical Education and Recreation of Catonsville Community College.

Reflections on the 1968 Olympics Conducted at High Altitude

The prime reason for our success at the 1968 Olympic Games was our early formation and training at Lake Tahoe.

THOMAS F. WADDELL, MD
Montefiore Hospital
Bronx, New York

My reflections on the 1968 Olympic Games could be a very diffuse subject. Now, the games themselves seem to have been just a fleeting experience compared to the several months I spent at the high altitude training camp at South Lake Tahoe. It was this training period, in fact, that made the Mexico City Olympics the most astounding ever in terms of performance. Nineteen world records were tied or broken in track and field alone and almost every Olympic record fell at Mexico City.

The questions that most people asked following the Mexico City Olympics were, "What happened down there? Why did everyone do so well?" The answers are numerous, few of them are based on fact, and most are speculative at best. I have my own list of possible answers to those performances and I'll be the first to admit that my priorities in terms of importance are quite subjective and are not the result of any formal study.

I did have the advantage of following the team in a dual role, ie, as a competitor and as one of the purveyors of the health service to the team, from the training period to the games.

The prime reason for the success of the team was its early formation at South Lake Tahoe. This happens to be a controversial subject because the official date for formal team workouts is to be one month before the games. This team met on July 17, approximately three months prior to the games. Ostensibly, each athlete received a specific invitation to participate in a medical testing program. I don't think that any American team has ever undergone such a concentrated effort prior to the Olympic Games.

The 400 participating athletes lived in trailers on a mountaintop next to an abandoned ski slope. While they had a training table, there were liberal hours for eating. They had a physical examination room, a weight training room, a universal weight machine, and sick call available to them.

Few athletes had cars and it was 20 miles to the nearest casino (across the state line in Nevada). This discouraged younger team members such as Casey Carrigan and Larry James, even though there were no curfews imposed.

The athletes were permitted to seek their own training levels. Coaches were available, but very few had anything to teach the youngsters who had already reached world class in their events. The lack of rapport between athletes and coaches was understandable since athletes had no voice in the coaches' selection.

Yet, there was an easy atmosphere that was conducive to training. I was stimulated by the comraderie and friendly competition. There was an honest desire among the athletes, with very few exceptions, to help each other improve and to push for better performances.

A video-tape machine was available for the last few weeks before we left for Denver. This device should have been there from the first day. By seeing themselves in slow motion, the athletes appreciated more fully the verbal criticism they sometimes received from the coaches. I would strongly advocate the use of this training device as a means of pointing out deficiencies.

Another factor in the success formula was the simulation of conditions which would be encountered in Mexico City. We had an identical track and runways, and we practiced at an altitude approximately 20 feet higher than Mexico City. In fact, there was even an attempt to simulate the water conditions. We drank from a spring-fed water supply which had its origin in the mountains above the camp. Apparently it was a popular animal watering area as well. An epidemic of diarrhea occurred in the camp and this was traced to a high coliform count in the drinking water.

There were curious phenomena associated with training at 7,400 feet. When I arrived at this altitude, I did not feel any adverse effects for about three days, other than some shortness of breath on exertion.

From the fourth day to about the third week, however, there was a period of easy fatigue and a sensation of heaviness. It took great effort to move and I had a constant feeling of weariness after a race.

After three weeks there was a gradual return of normal respiration and a feeling of well being. The noticeable fatigue was no longer reflected in different responses, but was shown by general weakness and periodic leg cramps. I felt "high" during this acclimatization period. But vital capacity was increased, probably as a result of a diminution of the functional reserve volume.

I did not see any high altitude pulmonary edema at Tahoe, though this is usually reported at altitudes higher than 10,000 feet. Nor did I see any sickle cell crisis in any Negro athletes, either at Lake Tahoe or in Mexico City. No sickle cell screening was done, to my knowledge, but statistically there should have been several athletes out of the 1,000 or so competitors with sickle cell traits.

I did see one case of diaphragmatic spasm, secondary to anoxia, in Jim Kemp immediately after he ran a world-record 300 meters. This problem cleared up immediately but was frightening to watch.

Another highly publicized factor in the history of the 1968 Olympics was the use of drugs. There was widespread use of analgesics, anti-inflammatory drugs, anabolic steroids, cortisone, and ACTH, and the most gross abuse of vitamins and minerals that I have ever encountered. Many trainers and several coaches were among the most outspoken proponents for the use of these drugs. However, I think the medical profession should conduct controlled studies on the effect of these drugs in healthy young people.

I saw severe acne result from the anabolic steroids. And I saw diarrhea develop from inorganic phosphates which were passed out by a group of name coaches who supposedly had developed the compound. I also saw athletes eating up to 10,000 mg of vitamin C in a single day, while others were getting shots of 1,000 mg of vitamin B_{12} an hour before their competition. There are a great many myths associated with vitamins and I think it is fortunate that no serious effects have been noted to date. But the general lack of danger is a very unscientific reason for their injudicious administration, particularly when the beneficial effects have not been proven.

I should mention that we had the services of Dr. Carl Stough, of the Carl Stough Breathing Institute. He has developed a method of diaphragmatic breathing, which up to now has been significantly successful in treating persons with chronic lung disease. Diaphagmatic breathing is efficient, but is not an easy thing to do when you are keyed up during a race. All of us have seen athletes straining while running and have realized that they were not getting the most efficient air exchange. Dr. Stough studied the Yale team two years ago and volunteered to work with us at Tahoe. Most of us who took advantage of his classes began to feel better during workouts and this may have also made a difference in the performances. I think the method should be employed by coaches for all strenuous events, even at sea level.

There were other reasons for the athletes' success, but eventually it always depended on the athlete himself. I think, though, that the early formation of the team, the video tape, and the simulation of conditions at Tahoe, all aided the final performance.

Heat and cold are the two most generally accepted physical measures used in modern athletic rehabilitation. However, therapeutic exercises, massage, splinting, and compression bandaging are becoming increasingly more important in the restoration of the injured athlete to maximal functional capacity.

Physical Medicine in Athletic Rehabilitation

ALVIN M. BROWN, MD
Director
Department of Rehabilitation Medicine
Flower and Fifth Avenue Hospital
New York, New York

Physical medicine concerns itself with the use of physical measures in the treatment of diseases and injuries. In the evolution of physical medicine, the various procedures have been grouped as thermal, mechanical, electrical, and chemical. These classifications, however, are not delimited. Thermal measures, for example, cause mechanical, electrical, and chemical changes. Methods termed mechanical produce thermal, electrical, and chemical variations. Similarly, electrical and chemical measures can be responsible for changes to which these other terms may be applied. One can readily see, however, that this general approach to the use of physical agents in athletic rehabilitation can be quite confusing.

Physical measures most commonly used in modern athletic rehabilitation are: heat, cold, therapeutic exercises, massage, splinting, and compression bandaging with elastic bandages or adhesive tape.

Heat and cold are perhaps the two most generally used physical measures and the modalities most often used in providing heat and cold are as follows:

I. Hydrotherapy: external application of water furnishing superficial heat and cold
   A. Whirlpool bath
      1. Cold: 35° to 50° for 20 to 30 minutes
      2. Hot: 100° to 115° for 20 to 30 minutes
   B. Hydrocollator packs: canvas enclosed packs of silica gel heated in water to 140° to 160°. Several layers of towels are placed between the pack and the skin.

II. Electromagnetic radiation (deep heat)

A. Short wave diathermy: therapeutic application of high frequency currents to produce heating of tissues (2 to 4 cm). Most machines operate at a frequency of 27 megacycles with a wavelength of approximately 11 meters. The contour applicator (drum) is most widely used. Intervening layers of toweling are used to absorb perspiration. The treatment time is 20 to 30 minutes.

B. Microwave diathermy (deep heat): operates at a frequency of 2,450 megacycles with a wavelength of approximately one meter. It has A, B, C, and E directors; the B director is used most often. The treatment time is 20 to 30 minutes.

III. Ultrasound (deep heat): a form of acoustic vibrations occurring at frequencies of 0.7 to 1.1 megacycles per second. These mechanical vibrations are converted to heat (4 to 8 cm). A coupling agent is needed, such as water (70° to 75°) or aquasonic. Standard treatment is 1.5 wts/cm^2 for 6 to 8 minutes with aquasonic or 2.0 wts/cm^2 using water.

Superficial heat in the form of hydrotherapy is universally safe in the treatment of athletic injuries, but deep heating agents such as diathermy and ultrasound are not without dangers. Precautions in the use of diathermy are as follows:

1. All clothing should be removed from the areas to be treated, in order to eliminate its effect on radiation.

2. Patients should experience only a pleasant sensation of warmth during treatments.

3. Patients should report burning or pain at once. These should be used as an indication for stopping treatment or reducing dosage.

4. All metallic objects should be removed from the region of treatment. Metal objects may concentrate the field and cause burning.

5. Care should be exercised in treating over superficial bony prominences in order to avoid overheating.

6. The area under treatment should be kept dry.

7. Diathermy treatment should be avoided through plaster casts, adhesive strapping, etc.

8. Avoid treatment over areas with noninflammatory edema and thrombophlebitis.

Precautions in the use of ultrasound are as follows:

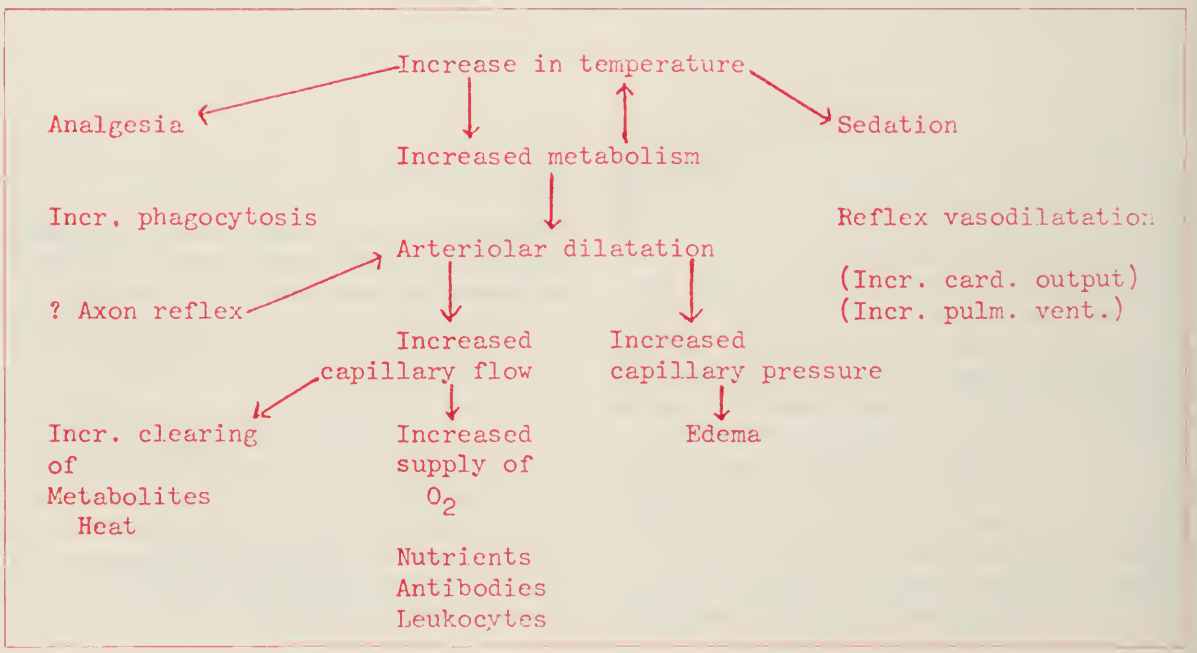
1. It should not be used over epiphysis of growing bones.

2. It should not be used over the reproductive organs, the heart, the eyes, the lower cervical sympathetic ganglia, and directly over the spinal column.

The physiological effects of local heating of athletic injuries are depicted graphically in Figure 1.

The physiological effects of local cooling are shown in Figure 2.

Figure 1: Physiological Effects of Local Heating [1]



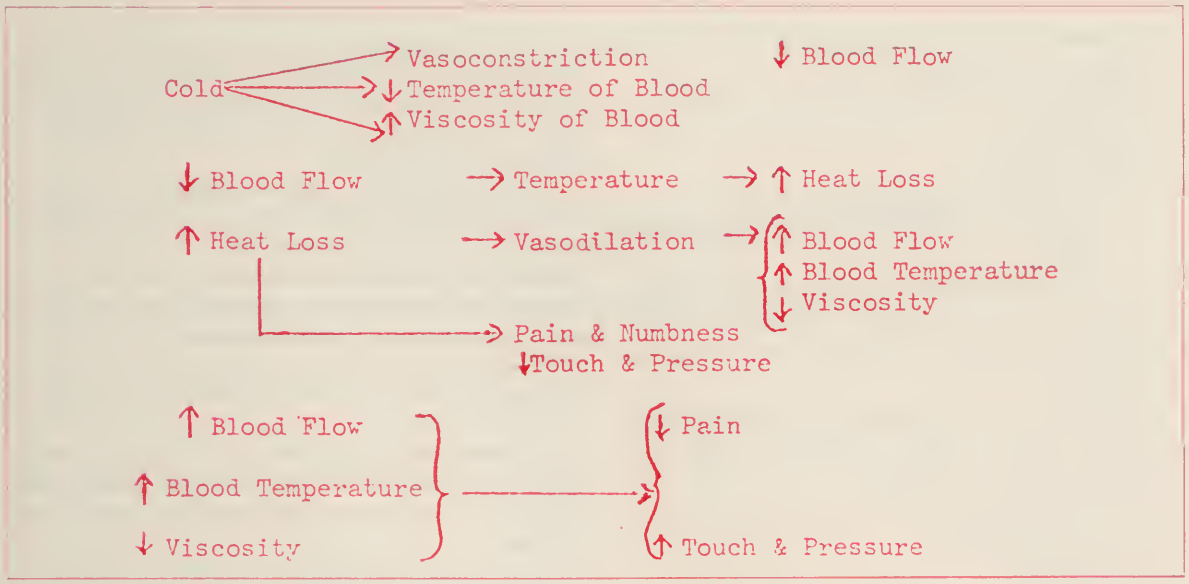


Figure 2: Physiological Effects of Local Cooling

Massage is a term used to signify a group of systematic manipulations of body tissues which are performed with hands for the purpose of affecting muscular relaxation and sedation. It is perhaps the oldest of all physical methods of treatment as it is an instinctive act. As a tool in the management of athletic injuries, however, it is receiving less and less emphasis today. The most frequently used massage technique today is that of effleurage, a stroking type of massage. Kneading and frictional compression massage are used most often for muscle cramps and chronic muscular conditions, such as fibrositis, respectively. Tapotement (hacking) is rarely used today.

Therapeutic exercises, a rarely used physical measure in past years, are becoming increasingly more important in the restoration of the injured athlete to maximal functional capacity. They may be defined as the prescription of bodily movement to correct an impairment, improve musculoskeletal functions, or maintain a state of well being. Types of therapeutic exercises are:

1. Active exercises (patient performs movement) to maintain muscle strength and joint range.
2. Active assistive exercises (patient is helped in performing movement) to mobilize weak muscles.
3. Passive range of motion exercises (involved muscles are moved for patient) to maintain joint range.
4. Passive stretching exercises (stretching of soft tissue contractures) to increase joint range.
5. Resistive exercises (mobilization of muscles against resistance) to strengthen muscles.
6. Isometric exercises (contraction of muscles without joint movement) to strengthen muscles and maintain tone.

Splinting and bandaging are used primarily for immobilization, compression, and support in treatment of athletic injuries. Splinting is used most generally in the immobilization of suspected fractures, whereas adhesive strapping and elastic bandaging are used for both compression and support, and are quite widely used. In my experience, I have found that adhesive strapping properly applied is of the utmost importance in the early rehabilitation of the athlete. There are, however, many different methods of applying elastic bandaging and adhesive tape to the same type of injury. Bandaging also includes the use of a sling which is used primarily for immobilization.

Traction and gentle manipulation are measures infrequently used in athletic rehabilitation. These physical measures should be left to the judgment of the physician because of the damaging results that can accrue from the indiscriminate use of these methods.

Rehabilitation is a term that is synonymous with restoration. In athletic rehabilitation, we are concerned with the restoration of an athlete to his maximal functional capacity, not only physically, but also psychologically. There are concomitant social and vocational values accrued especially in professional athletics. In order to most efficiently utilize physical medicine in athletic rehabilitation, one has to properly diagnose the condition being treated and appropriately select the physical measures to be used.

The most common injuries confronting athletes in strenuous sports are as follows:

1. Contusions: direct blow causing bruising of the skin and underlying tissue
2. Hematomas: collection of pooled blood in a restricted area
3. Open Wounds
   a. Abrasion: scraping injury to skin
   b. Laceration: separation of skin with irregular edges
   c. Puncture: wound by a penetrating object
4. Strain: injury to muscle or tendon, or both
5. Sprain: injury to joint and surrounding ligaments
6. Dislocation: displacement of a bone forming a joint with or without ligamentous damage
7. Inflammatory conditions
   a. Tendinitis
   b. Tensosynovitis
   c. Bursitis
   d. Capsulitis
   e. Lymphadenitis
8. Fracture: discontinuity of bone structure
9. Cramps: muscle spasm

A general approach to the use of physical agents in the treatment of athletic injuries can be simplified if one properly categorizes the problem confronting him. All injuries are divided into acute, subacute, or chronic conditions, or all three.

In musculoskeletal injuries, such as strains, sprains, dislocations, and fractures together with contusions and hematomas, the acute phase generally lasts from 24 to 48 hours. Its onset is at the time of injury and it ends with the stabilization of the cardinal signs of musculoskeletal tissue injury such as swelling, increased tenderness, heat, discoloration, and limitation of motion.

The inflammatory conditions are generally secondary to a previously existing musculoskeletal injury and the cramps are generally self-limiting. Open wounds will be discussed separately from the above mentioned injuries.

The subacute and chronic stages of the above mentioned injuries last for varying periods of time. These stages last collectively from the period of cardinal sign stability to the time when the athlete is free of all signs and symptoms of his injury.

Generally speaking, the approach to treatment in the acute phase can be summed up in three letters, "ICE". These letters stand for ice, compression, and elevation.

Ice or cold prevents excessive swelling and decreases pain (see Figure 2). It reduces the development of the other cardinal signs of musculoskeletal injury, for example, heat, discoloration, limitation of motion, and tenderness.

Compression also aids in reducing swelling by compressing the extra compartmental circulatory spaces.

Elevation is merely a mechanical measure to enhance local circulation by improving venous flow to the heart. Naturally, the dislocation has to be realigned properly prior to applying these measures, and the fracture has to be splinted before mobilizing the injured athlete.

Treatment during the subacute and chronic stages can be summed up in the following three letters, "HEM". These letters stand for heat, exercise, and massage.

Heat decreases swelling by a different mechanism than cold does (see Figure 1). It facilitates the resolution of the cardinal signs of musculoskeletal injury.

Exercises of a therapeutic nature are used for maintenance of muscle tone, strengthening, and regaining normal joint range.

Massage is a mechanical method of enhancing circulation and can be done manually or through the use of whirlpool baths or ultrasound.

It is my opinion, however, that superficial heating agents are most effective in the early subacute stage and the deep heating agents are most effective in the late subacute or chronic stages.

Open wounds can be treated simply by first stopping the bleeding by direct pressure and then thoroughly cleansing the wound prior to the application of a sterile dressing. Lacerations, however, often have to be sutured. On the other hand, dressings are not always necessary for abrasions as they often heal faster when left exposed after thorough cleansing.

To summarize, physical medicine activities properly prescribed can be of the utmost importance in athletic rehabilitation. However, for restoration of the athlete to his maximal functional capacity, the following requirements are necessary:

1. **Etiology of injury or how athlete was injured**
2. **Significant past medical history**
3. **Basic knowledge of anatomy, physiology, and kinesiology**
4. **Proper management and selection of physical methods during the acute, subacute, and chronic stages of injury**

REFERENCE

1. Krusen, F. H., Kottke, F. J., and Ellwood, P. M.: *Handbook of Physical Medicine and Rehabilitation.* Philadelphia: W. B. Saunders Company, 1965, p. 234.

A superbly fit athlete with a love for her sport is hard to hold down. Her enthusiasm for her sport is bound to reflect in her enthusiasm for life and for whatever else she does. Yet, I feel that we, who are in the position to do otherwise, have neglected to encourage young women to participate in competitive sports.

Athletic Competition for Girls



TENLEY ALBRIGHT, MD
Boston, Massachusetts

Many of the reservations about girls in athletic competition connote concern about menstrual cycles and childbearing. However, studies have shown beneficial, rather than detrimental effects resulting from female sports participation. I find this concern especially among the scientists, officials, especially men, who worry about this much more than the girls themselves do.

This participation, in addition to helping an athlete stay in top condition, also helps her to fulfill her potential. Women can do many things and do them well and still remain feminine. In this country, we

can take as an example women jockeys, or even marathon track runners.

Similarly, the Russians have proven that a woman is quite capable of participating in space ventures. In Israel, women are drafted into the army. Granted, Russian space exploration and Israeli conscription are not forms of fitness participation, but both are examples of what women can and do accomplish, while still remaining feminine.

By taking part in sports, a dedicated athlete attains a state of fitness. This fitness means a lower basal heart rate and a higher pulse rate with exercising. It guarantees a more efficient stroking contraction power of the heart, and a better pulmonary function, with increasing vital capacity and greater ability to inspire a large amount of air and oxygen. Fitness offers the athlete lower blood pressure, flexibility, and muscle power. But most important, fitness gained through skating or other sports participation means being able to cope with life and its emotional as well as its physical strains. Surely these obvious advantages to be gained from athletic competition counter the argument proposed by some people that competitive sports adversely affect young women.

From my own experience, I feel qualified to urge people to encourage young women to participate in sports, any sports. I want to tell you to recruit all girls for skating, but I won't. Instead, I will show you, by a case study of mine, the effects of sports competition in general, and skating competition in particular, on the life and habits of one young girl.

Kathy Taylor is an attractively shy and unassuming 13-year-old. She attends school five days a week but skates six days a week. She usually spends 2½ to 3 hours a day working on her jumps, spins, control, and precision tracing. The skating does not interfere with her studies as might be expected. On the contrary, the better her studies, the quicker she finishes, the more she can skate, and the better the chance that her teachers will sanction her missing a few school days to travel across country or across the ocean to attend a meet.

I said that Kathy was shy. She is, off the ice. On the ice, Kathy is bold in her own world of speed, height, and self-discipline. She matches herself against what she did the last time she stepped on the ice, and what she hopes to do the next time. She is completely free on the ice, yet her seriousness of purpose shows through.

Kathy's life is very complete. Besides her practice skating, she has half-hour lessons four times a week. She even had time to help a group of younger skaters plan a number for their Christmas skating pageant. Her skating gives her an appreciation of time. She balances her challenging schedule to fit in time for school, extracurricular activities, skating, friends, family, and home. From observation, I have seen Kathy learn how to handle competition both on and off the ice. I think skating has made her see how aims can be realized with effort.

Of course, Kathy has learned to accept the handicaps of her sport such as exhaustion, discipline, bruises, and stress. For the love of the sport, she endures. She knows what it is to achieve a sense of accomplishment, and she knows what it means to work hard. I feel that this sports participation has made Kathy a very interesting young lady and I do not feel that it has detracted from her femininity in the least.

I noted at the beginning that many people think that sports affect a woman's biological functions. But athletic training does not interfere with the rhythmic menstrual cycle. Stress perhaps, the emotional stress of a competition, may suspend or postpone the start of a period, but the normal cycle is soon resumed. Physicians find more complaints of irregular or missed periods from models or airline hostesses with drastic diets over a long period of time, than from athletes.

Women today do not get enough opportunities to exercise their bodies. True, they climb steps, pick up after the kids, and tangle with the vacuum cleaner, but this is not the real type of exercise to which their cave girl ancestors were accustomed. In order to survive, today's woman does not find it necessary to build a shelter or to run down an antelope. But yet, women have this inherent potential. They could still do these things if they had to.

General James Gavin of Cambridge, Massachusetts, feels that friendly competition with extreme physical activity and all-out effort can prepare young adults to coexist in the world in a friendly atmosphere on a large scale.

Studies, particularly the Helms Study which was part of Project Talent conducted by the National Football Foundation, have shown that the term "dumb athlete" is a misnomer. There has proven to be a definite positive correlation between athletic competition and mental aptitude.

Mothers, then, need not fear that participation in sports will hamper their daughters' scholastic achievement. On the contrary, sports participation, particularly serious athletic competition, can offer any young woman a sense of release. It affords her the chance to give her all, and to relish that sense of accomplishment that results from doing a job well. It helps her to develop into a more conscientious individual by teaching her self-discipline. It really makes her a more interesting person and, in turn, a more feminine woman.

Today, we are finally realizing the importance of investing both time and money in furthering athletic programs for women. We should do this because a sound mind and a sound body do go hand in hand. The Greeks realized this fact centuries ago. It's about time we did too.

The Use of Drugs in Athletics

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A major problem today is drug abuse among young people. In athletics, many different drugs have been used in the past and are now being used to enhance an athlete's performance and to hasten his recovery. We, as adults, must help them develop the respect for drugs that can only come from their judicious use. Let's be sure that we are working with the "natural" athlete and not one who, through the excessive use of drugs, is forced to perform at a level far past his normal limitations.

We have gone through the stone age and the iron age, and through ages of conquest and war. While today's times can be given many labels, one which certainly applies is "the drug age". It began approximately in 1950 and has lasted 20 years. While it is true that many drugs were available for centuries before this age, it wasn't until the 1950's that such a vast number of drug products became available. These included new, more specific therapies and older products made more effective and less toxic. A professional and public confidence in the effectiveness of these drugs soon developed, a confidence based on the idea that these drugs were almost totally specific and nontoxic in their actions.

We unfortunately developed an overconfidence in the use of these agents and, with this, an often indiscriminate and uncautious approach to the prescribing and taking of drugs. This led to drug misuse and the problem of drug abuse that we see today. The casual use of drugs by often well-meaning adults has helped to set the proper conditions that trigger the widespread drug abuse problem. One can attempt to place the blame for our problems on many people, and even on society as a whole. But the time is past when we can afford to continue looking for someone to blame, when instead we should begin to tighten the manner in which we use drugs.

This does not imply increased legislation and longer jail sentences. This is not an answer. We must turn to a more discerning use of these agents. This could and should mean that fewer drugs will be taken.

Each of us must take a greater responsibility in our own use of drugs, each of us as a patient—whether we prescribe for ourselves or take medicine prescribed by a physician or dentist—each of us involved in the control of drug distribution, each of us as a parent or neighbor. This responsibility becomes extremely important when one is dealing with young people, not only because of the problems that involve drug abuse, but also because of the fact that

drugs may elicit unwanted or adverse reactions in young, developing adolescents.

How can we use drugs more judiciously? The first thing is to recognize that many drugs are toxic, not only in high doses, but even in doses used therapeutically. Tunnel vision in the use of drugs cannot be allowed to continue. Drugs should only be used when a clear therapeutic indication exists, and not to unnecessarily alter the normal physiological processes.

Many different drugs have been used to enhance an athlete's performance and to hasten his recovery. *Sports Illustrated* recently discussed some of the less than ethical practices used by a few physicians, trainers, or coaches. Why is it wrong to use some of these drugs as these people did or are still doing? The lack of morality is argument enough against this, but the adverse reactions that may occur are also a strong reason not to follow this line of misguided therapy. What are some of these reactions?

The amphetamines have been used to enhance athletic ability and reduce fatigue, but central nervous system stimulation is not the only pharmacologic effect caused by these drugs. They will also increase the heart rate, raise blood pressure, suppress appetite, slow intestinal contractility, etc. The initial stimulatory effect is followed all too often by depression and a heightened sense of fatigue. They have a high potential for abuse and one of the derivatives, methamphetamine (speed), will soon be singled out for strict control under the new federal laws.

The use of anabolic steroids to hasten recovery of muscle damage or to enhance muscular development has no place in athletics. These drugs are chemical derivatives of testosterone, the male sex hormone and, while they do not have as potent an androgenic effect as the parent drug, they can still exert a similar effect. High doses of these drugs actually suppress testicular activity, and may reduce the final height achieved by the boy.

The use of proteolytic enzymes to treat inflammation or reduce edema in traumatic injuries can be dangerous. These enzymes are nonspecific and will also break down the normal barrier the body builds around an infection and allow it to spread.

Vitamin B_{12} has little rationale for use in athletics unless the athlete has pernicious anemia. In a well balanced diet that most training tables are supposed to provide, there is no need for supplemental vitamins of any kind.

Ethics are a necessary part of our society. They are even more important in dealing with competitive events involving athletes that are developing in mind as well as body. It becomes important to restrict the use of drugs to only clearly indicated conditions. This will hopefully foster a respect for drugs by these athletes who are quite often school leaders. To aid in the restriction of the use of these drugs, each group involved in the coaching, conditioning, or treating of athletes should have a well-defined policy concerning their use of drugs. The policy that follows, adopted by the Santa Clara Medical Society in California, is an example of such an ethical code.

The following policy statement regarding the use of potentially hazardous drugs by athletes, to artificially improve their performance, was unanimously adopted by the Council of the Santa Clara County Medical Society at their March 3, 1969 meeting.

1. In the words of the International Amateur Athletic Federation: "no agent which stimulates muscle and nerves, or paralyzes the sense of fatigue or is habit forming should be used by any athlete".
2. To be more specific, as stated by the National Federation of State High School Athletic Associations and the Committee on Medical Aspects of Sports of the American Medical Association, "whether done unknowingly, tacitly, secretly or openly, the use of unwarranted ergogenic aids in sports is to be unequivocally condemned". The definition of ergogenic aids is "those drugs used to increase the capacity of bodily and mental effort especially by eliminating fatigue symptoms". Under this broad category especially the anabolic-androgenic steroids and amphetamines should be singled out for condemnation.
3. There is no excuse for giving anabolic-androgenic steroids to healthy athletes of any age and especially adolescents. The ill effects of the anabolic-androgenic steroids such as decreasing ultimate height, virilization, precocious puberty. testicular atrophy, decreased libido and liver function changes are insidious and are not immediately apparent.
4. Speaking on the amphetamines, these are the most widely abused non-narcotic drugs and when used to push the athlete beyond his normal endurance level can be harmful and even fatal, not to mention the problem of dependence and ultimate psychosis that is all too prevalent a complication lately. There is also no place for the use of amphetamines in a well conditioned athlete under the guise of being an appetite suppressant. No person in competitive athletics should be taking any amphetamines for therapy of any condition while he is competing. If the condition is such as to warrant their use then this condition should disqualify the participant from the athletic program.
5. There is no conclusive evidence that nutritional ergogenic aids such as food and vitamin supplements or oxygen have a place in a training program for normally nourished, well conditioned, healthy athletes.
6. The available evidence indicates that the usefulness of oral or intramuscular enzymes has not been established.

The special health hazards inherent in athletics often lead to valid medical reasons for administering a drug or drugs to an athlete. Drugs used in these instances are often called "restorative" drugs, or drugs that provide immediate physical relief to an injured athlete and hasten his recovery. It must be emphasized that restorative drugs are not intended to be administered to an injured athlete for the purpose of allowing him to continue competition in spite of the injury. In all but the professional athlete, this represents a grave example of drug abuse.

The Use of Drugs in Athletics

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Many drugs have little or no rationale behind their use in the normal, healthy athlete. These drugs have often been referred to as "additive" drugs, or drugs used with the sole purpose of stimulating the athlete or increasing his performance beyond natural limitations. Many of these additive drugs are particularly dangerous because they further strain physiological systems already strained by physical exertion and, furthermore, mask the symptoms of developing fatigue or exhaustion.

One of the most common occupational hazards of athletic competition is, of course, pain, and includes not only the pain of serious injury but also the continuous small aches and pains. An athlete is often distracted by even the smallest pain, probably because he is aware that he has access to drugs that will provide relief. Thus, it is not so unusual that pain represents one of the most common reasons drugs are used in sports.

There are two general kinds of anti-pain drugs: the local anesthetics such as Novocain, Xylocaine, and ethyl chloride spray; and those that suppress pain

by acting on the central nervous system, including morphine, Demerol, codeine, and pentazocaine (*Talwin*). While these drugs will relieve pain, it should be remembered that the cause of the pain must be determined and eliminated rather than masked by drugs. No competent trainer or physician ever administers a pain-killer and sends the athlete back into competition if the injury involves a weight-bearing structure. If a boy continues to play with an injured knee or ankle, it is obvious that the injury can be aggravated. One cannot help but wonder how many athletes suffer serious injury later in their career because they played with injuries masked by pain-killers. Is the immediate victory really worth the possible permanent crippling injury to the athlete and the prevention of a possible professional career?

There are, of course, other problems associated with the use of pain-killers. Xylocaine often causes sedation, and the continuous use of Novocain, depending upon the individual, can produce side effects ranging from excitation to coma to convulsions, as well as many allergic-type reactions. The potent narcotic agents present the added danger of developing a tolerance to the pain-relieving properties of these compounds. If the athlete manages to escape aggravation of the injury, larger and larger doses are needed to suppress the pain. Aside from possible physical and psychological addiction, a real problem is that he does not develop tolerance to other effects of these compounds. These effects include pupillary constriction with possible interference with vision, contraction of bronchial smooth muscle which would contribute to respiratory difficulties and, finally, severe constipation. All of these will impair the athlete's capability to compete satisfactorily.

A special category of pain-relieving drugs includes the anti-inflammatory compounds such as cortisone, hydrocortisone, and Butazolidin. These compounds are often injected into the synovial space of injured joints to relieve swelling and inflammation. Contrary to popular belief, the use of these compounds can be extremely dangerous, even toxic, especially when used over extended periods of time as they are often used in sports. The biggest danger is that although the inflammation is relieved, the cause of the inflammation is not. Therefore, the athlete must be cautioned to limit activity of the treated joint even though there is distinct symptomatic relief, as the inflammation remains active and use of the joint may accelerate cartilage deterioration. Cortisone can lead to the gradual degeneration of bone structure. Thus, the continued use of cortisone to relieve pain and swelling in a pitcher's elbow while he continues to pitch may lead to degeneration of the elbow with crippling results. The same applies to a fullback's knee. Butazolidin produces toxic reactions in about 25% of those persons treated with it. These range from peptic ulcer to bone marrow depression to fatal blood disorders. It should be obvious that the promiscuous use of these drugs in order to keep an athlete in competition is to be avoided and condemned.

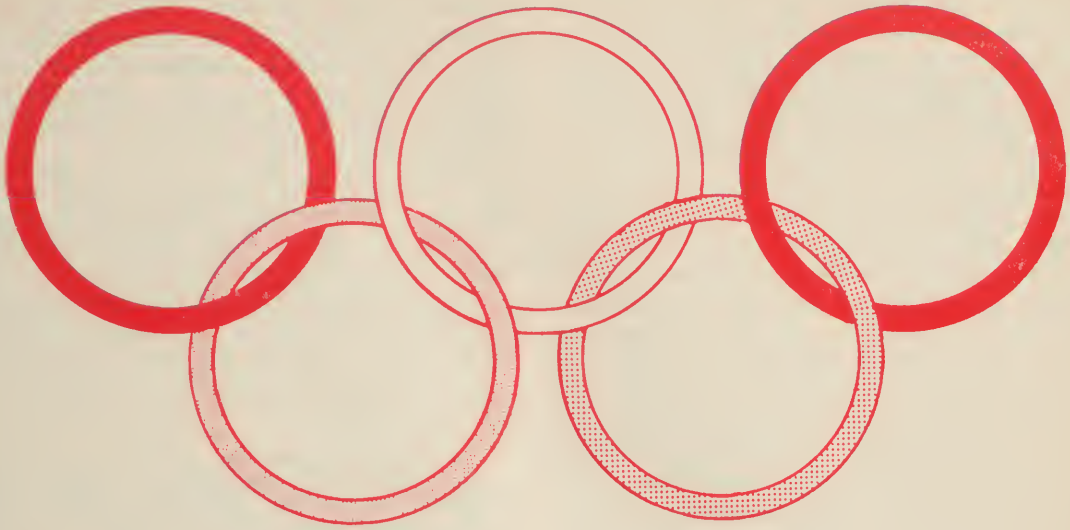
In addition to pain, a frequent problem encountered in athletic competition is the ever-present tension and continued pressure placed upon the athlete to win. Many athletes may need and even demand antispasmodic and tranquilizing drugs to control pregame jitters and nausea. Considerable variation in opinion exists among coaches and trainers as to the use of these drugs, since the problems encountered are ethical, rather than medical. The natural limitations brought about by an athlete's inability to deal with pressure should not automatically make him eligible for a tranquilizer. The same principle applies to those athletes as applies to those taking pep pills: They are attempting to derive something from the use of drugs which they do not think they naturally have.

Another problem arises from the fact that any of these tranquilizing drugs—Miltown, Nembutal, Equanil, Librium, Thorazine, etc.—cause some degree of sedation. Since these drugs are often given to athletes participating in action or motion sports, the trainer or team physician who administers them is often walking a tightrope between calming the athlete and sedating him to such a degree that his athletic ability is impaired. The high-strung and jittery cornerback may be calmed before the big game but may be so sleepy during the game that he is beaten on a pass pattern.

Many of the preparations, especially the antispasmodics, contain ingredients which affect the innervation of the eye, causing blurred vision. This could be especially disastrous to a baseball or basketball player. In addition, an important consideration is the development of potentially hazardous drug interactions involving the central nervous system resulting when more than one of these compounds is administered simultaneously.

In spite of the specific instances where the "restorative" drugs may benefit the injured athlete, we must remember that drugs are meant only for the treatment of injury or disease. They are not meant to be used as a "chemical-crutch" to substitute for the natural physical or psychological athletic prowess of the sports competitor. I think it is justified to again stress that no drug should be used for the sole purpose of keeping an athlete in competition. If the injury or emotional disorder is serious enough to warrant the use of drugs, the athlete should not be allowed to compete until the problem has been solved.

And finally, you are again charged with the responsibility of setting the example of intelligent drug use to the young people of our society. They, in turn, can develop a respect for drugs and will, hopefully, avoid the indiscriminate and uncautious approach to drug use which so often leads to drug abuse.



Psychological and Psychosomatic Problems of Athletes

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The psychological problems of athletes are those related to behavior. Likewise, anything influencing the mental processes or behavior of the athlete can have an effect on him physically. Aggression, anxiety, motivation, level of aspiration, self-confidence, courage, emotional state, tolerance of pain, proper state of mind, fear of failure or fear of success, and self-esteem are some of the factors related to performance.

In any discussion of the psychological and psychosomatic problems of athletes, it must first be clearly understood what is meant by the terms psychological and psychosomatic. According to Dorland's Medical Dictionary, psychological relates to the scientific study of mental processes and behavior.[1] Literally, "psycho" means mind, and "soma" body, thus psychosomatic means mind-body relationships.

On the basis of these definitions, it is apparent that the psychological problems of athletes are any problems related to behavior and can be multitudinous. Likewise, anything influencing the mental processes or behavior of the athlete can have an effect upon him physically. Therefore, athletic problems can be caused by environmental factors such as disease, infection, hunger, drugs, heat, and cold. Other problems can arise from society. Competition, city life, home life, and boy-girl relationships may influence the performance of the athlete. Lastly, and most importantly, athletic problems may be psychological in nature. Some examples of psychological problems may be a lack of motivation, anxiety, fear, aggressiveness, and doubt in one's manliness or ability. It should be apparent that the problems of the athlete may arise both from within the individual or without.

Before I look specifically at some of the above proposed psychological problems, I would like to carry the above discussion a bit further to relate to you the importance of these internal and external factors influencing performance. Every successful coach must know the total athlete, that is, he must not only know what is influencing the athlete physically, but he must also know what is influencing him mentally, socially, and emotionally. Ken Doherty, Track Coach of the University of Pennsylvania, describes the type of training required to secure top performance as the "Holistic Theory of Training".[2] In this theory, the coach must not only train the athlete physically, that is, increase his endurance, make sure he is getting the proper diet, rest, and so forth, but he must also learn as much as possible about the athlete's emotional, mental, and social problems, so that he may train the *total* athlete.

We have all seen an underrated team soundly trounce the obviously superior team. (With hesitation and tongue in cheek, I might mention to Baltimore fans their experience with the New York Jets and New York Mets.) What are these intangible factors that separate a winner from a loser? Is it a proper state of mind? Is it motivation? Is it the proper emotional state? Is it fear of success? Is it the athlete's level of aspiration, or is it confidence in self? Why does a group of athletes who are apparently going all out, but losing, suddenly catch fire? Why does coaching strategy succeed in one game and fail in another?

Reuben Frost noted in a recent talk at the National Convention of the American Association for Health, Physical Education and Recreation, that answers to these questions are not readily available. He said, "Involved are nebulous, intangible things like feelings, ambitions, desires and inner resources. We must try, however, to apply some of our scientific knowledge to these situations and see if we can approach a few answers." [3]

Considerable research has been conducted over the past 20 years to study answers to these questions. Of particular interest is the research conducted on the personality characteristics of champion athletes. In a paper entitled "Sport and Personality Dynamics", recently presented at the 72nd meeting of the National College Physical Education Association for Men in Durham, North Carolina, I summarized this research as follows:

> **"Apparently, there is some basic agreement as to the personality traits of some athletic groups, particularly champion athletes. Johnson, Hutton, and Johnson, Ogilvie, and Kane agree that, in general, champions:**
>
> **1) are or have the need to be more aggressive,**
> **2) are more extroverted in team sports,**
> **3) have exceptional feelings of self-assurance, and**
> **4) have greater abstract reasoning ability.**
>
> **There is considerable disagreement over the level of anxiety and the ability of champions to control their emotions."** [4 (p 63)]

It is of interest that the psychological and psychosomatic problems of athletes are involved with these personality characteristics. For this reason I have arbitrarily arranged the problem areas to be discussed under five headings: motivation, aggression, level of aspiration, stress and anxiety, and fear of success.

Motivation

One of the major problems of the athlete and athletic coaching is that of motivation. Motivation, for the purposes of this discussion, relates to the basic human needs which energize behavior. These human needs are extremely complex and difficult to identify. According to some psychology theorists, these needs or motives are learned, while others believe many of these needs are innate to the human organism. Some believe that these motives are for the most part conscious, while others believe that they stem from the unconscious. The theorists who believe that motives are learned believe that behavior which is pleasurable, that is, behavior which is rewarded in some way, results in an attempt by the organism to repeat this behavior. If an athlete participates in sport for social acceptance, self-esteem, an athletic award, etc., he would be motivated by learned conscious habits. Those theorists who believe that behavior is driven by some innate unconscious

factor, usually the traits of sex or aggression, believe in Freudian psychology. If the athlete participates to relieve his aggression or to alleviate a feeling of masculine inadequacy, or to develop a beautiful body, he is said to be motivated by unconscious drives.

The former theory, that motivation is learned, is the most common sense theory and the easiest to understand. I believe I can safely say that most coaches base the motivation of their individual athletes and athletic teams on this theory. Award, reward, security, companionship, new experiences, the desire to be held in esteem and, in some cases, to be punished are all techniques successfully used for motivation. The athlete is aware or conscious of this type of motivation.

The unconscious motives are much more difficult to comprehend, unless one has special training and spends considerable time in analyzing the behavior of his athletes. Unconscious motives are not easy to identify since they are disguised by such psychological mechanisms as rationalization, regression, repression, and sublimation. According to Maslow and Mittlemann, unconscious motives usually involve the avoidance of pain, danger, or emotional hurt, or the protection of self-esteem or security.[5]

To emphasize the complexity of motives, I would like to cite as an example the athlete who is motivated to excel in athletics, since this may be the only basis for acceptance at home. If the athlete fails to succeed, he will feel unworthy. The father humiliates the athlete by constantly forcing him to further athletic endeavor, when he is not capable. It is also possible for the athlete to resort to unethical tactics to satisfy his parent's unwholesome competitive need. This type of motivation is dangerous, and certainly is not conducive to an outstanding performance.

It should be apparent that motivation and motives for participation are almost anything affecting the individual athlete. The psychological problems of athletes are interwoven with motivation or some aspect of motivation. I would now like to turn to the second problem area, namely, that of aggression.

Aggression

Some of you will see a relationship between the need to be aggressive, mentioned as a characteristic of the champion, and motivation. That there is a relationship between aggression and motivation is substantiated by Storr in his book *Human Aggression:*

> **"One difficulty is that there is no clear dividing line between those forms of aggression which we all deplore and those which we must not disown if we are to survive. When a child rebels against authority he is being aggressive: . . . The desire for power has, in extreme form, disastrous aspects which we all acknowledge; but the drive to conquer difficulties or to gain mastery over the external world underlies the greatest human achievements. . . .**
>
> **"The aggressive part of human nature is not only a necessary safeguard against predatory attack. It is also the basis of intellectual achievement, of the attainment of independence, and even of that proper pride which enables a man to hold his head high amongst his fellows."** [6]

There is considerable evidence that participation in sports provides a socially accepted outlet for aggression without accompanying feelings of guilt. If an athlete has a high innate drive to aggress, sports participation may lower that drive, since the athlete is given the opportunity to aggress in the most violent way. This is especially true in football, wrestling, and boxing. As long as he participates within the confines of the rules, he may escape the guilt which usually accompanies the expression of aggression. (Some evidence substantiating this concept was provided by my dissertation where I was able to show that cross-country participants had considerably more extra-punitive aggression than boxers or wrestlers.) Since competition comes from the aggressive side of nature, these feelings of aggression should be discouraged if they develop away from athletic activities. Many athletes are troubled by feelings of guilt when forced to express aggression.[7]

Beisser, in his book *Madness in Sports,* has further described the importance of aggression to competition:

> **"The poor competitor has learned to fear aggression most of the time, the average competitor fears it occasionally and the good competitor fears it only infrequently. It has been observed that the poor competitor avoided aggression in many ways both on and off the field. They spoke softly, and they avoided arguments. They tried to maintain friendly relations with their rivals under all circumstances."** [8]

I am suggesting that in those sports where you compete at a distance, where you do not come in physical contact with your opponent, you may want to provide your athletes with some body contact sports as a part of their conditioning program. Now let us turn to the level of aspiration.

Aspiration

The achievement motive is directly related to the athlete's level of aspiration. For the purposes of this discussion, the level of aspiration is defined as the "standard by which a person judges his own performance as a success or a failure, or as being up to what he expects of himself".[9]

The athlete will evaluate himself on his opinion of self, that is, on his self-concept, and on the opinion of the ability he possesses. I am sure that some of you have seen the following reaction to defeat which is described by Ryan in a paper entitled, "What

does Psychology have to Offer Coaches and Trainers?", which was presented at the 68th annual meeting of the NCPEAM in Minneapolis in January 1965:

> **"One boy, after being beaten by a conference champion or national champion would be terribly disappointed or even shamed, while a second boy would suffer no discomfort under the same circumstances. In fact, the second individual might actually react as if he had won. Two boys, the same situation as far as the contest was concerned, but two completely divergent reactions to defeat."** [9]

According to Ryan, research has resulted in the following hypotheses regarding level of aspiration: [9]

1. **Success experiences usually lead to a rising level of aspiration.**

The implications for coaching here are obvious—schedule schools against which your team or the individual sport participant can consistently be successful.

2. **Failure generally results in a lowering of one's aspiration.**

This hypothesis tells us why teams which have a losing season one year, usually have a poor season the next year. The players, and perhaps more often the coach, indicate that they will have a successful season if they win half of their games.

3. **The effects of failure on levels of aspiration are more varied than are those of success.**

If an athlete succeeds, he almost always will set his sights higher. If he fails, he may set his sights lower, leave them the same, or set them higher. If the individual refuses to lower his level of aspiration, he may be protecting himself in two ways. First, it may help him to disregard the failure. And second, the social value of never admitting defeat strengthens the individual in his relationship with others. For example, if a high school athlete misses his high jump at 6′10″, rather than lower the bar, he again tries at the same height or raises the bar. If he again misses, no one can blame him for missing at that height.

Ryan writes, "If the individual experiences a performance below his level of aspiration, and sees it as a severe threat to his self-esteem, he may keep his level of aspiration low to prevent such a situation from arising a second time. (Or as mentioned above, the level of aspiration may be so high that no one could blame him for failing.) A boy, who thinks he might be beaten, rather than compete, may in some cases actually refuse to participate. He may fake an injury or illness or find all sorts of excuses for avoiding the contest." [9]

In fact, it may be possible that some athletic injuries occur because this is the one way the individual can still protect his ego and still be a winner. If this occurs, the athlete has solved his problem through psychosomatic methods. We certainly need further research to determine whether or not the athlete puts himself in an injury situation to satisfy some unconscious need.

Finally, failure or the possibility of failure decreases motivation, causes a loss of interest, and thus, a complete withdrawal from the task. I am sure we have all experienced the loss of athletes from our squads for this reason.

4. **In groups, where comparison with others in the group is possible, the level of aspiration always moves closer to the average performance level of the group.**

To avoid the few athletes who are considerably above the others in ability to set their level of aspiration lower than it actually is, a good coach will discuss goals with them early in the season and periodically during the season, in an attempt to keep them at a high level of aspiration.

5. **A person does not evaluate his abilities with others too divergent from himself.**

From the foregoing it can be seen that a high level of aspiration may represent a direct expression of a goal, an incentive to perform better, or a means of protecting the ego. A low level of aspiration may express an objective judgment, a method of avoiding tension, or a way of avoiding the appearance of failure. There is some evidence that a strong leader can alter the level of aspiration of a group which may have set their sights too low.

Stress and Anxiety

In coaching today, stress and anxiety are becoming important traits to consider because they have such a great influence on performance.

The sources of stress are perhaps best described by Reuben Frost:

> **"Stress normally causes a state of anxiety. Stress can be of many kinds. As previously mentioned, certain emotional states can act as stressors and lead to anxiety. Fear, anger, love, agony are examples of these. Criticism, disparagement, and punishment with accompanying anger and guilt feelings often develop into a stressful situation. Too many defeats, impending defeat and failure, and loss of esteem and status can be stressors. Ambition, a strong desire to win, or the desire to please a loved one can be equally stressful.**
>
> **"Stress can be imposed from within or can be the result of outside influences. A tremendous desire to achieve or pressure exerted by the coach or the alumni can act as stressors and produce an anxious state. It often happens that players and coaches put pressure on themselves even though there are no real outside pressures."** [3]

Each athletic contest is a stressor and normally produces some anxiety, both for the coach and the contestant. Research has shown that apparently there is an inverted U-shaped relationship

between anxiety or stress and performance (see Figure 1).

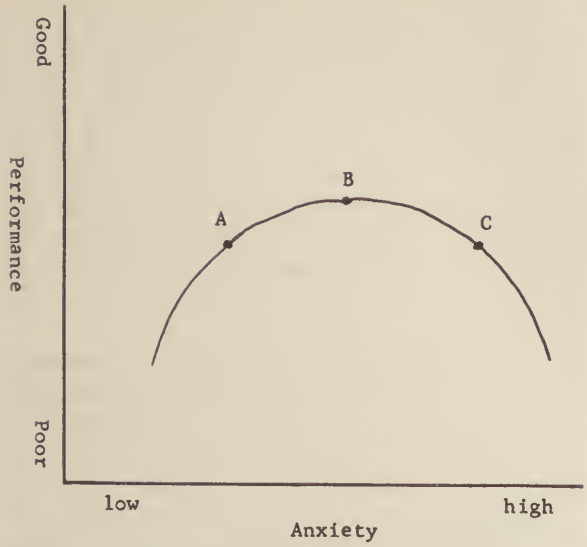


Figure 1: Relationship between anxiety and performance.[9]

If anxiety is low, the performance is poor. As anxiety increases, performance continues to increase, but then levels off. A continued increase in anxiety results in an increasingly poorer performance.

Individuals differ in their reaction to stress. Thus, each athlete has his own anxiety curve. When all persons were treated alike, psychologists looked for the highest average performance. When psychologists tried to raise the average performance, they began to treat each individual differently. I am saying that we cannot treat all athletes alike by giving a general pep-talk. The athlete at point "A" on Figure 1 has a low level of anxiety. To him, the game is just another game; he does not get excited about it. This athlete will be below the optimum performance level of anxiety and thus needs a pep-talk to get him to point "B". Another athlete, perhaps, has been in a state of anxiety because of the recent failure of an examination, and this stress, along with the stress of the contest, places him at point "B" on Figure 1 or at the optimum performance level of anxiety. For the third athlete, who has been under stress all week caused by a problem at home, the contest causes him to go beyond the optimum performance point (ie, at point "C" on Figure 1) on the anxiety scale. For this athlete the coach should use a pep-talk to calm him and relieve or lower his anxiety. It should be apparent that what is a stressor for one athlete may not be for another, and that each individual will respond differently to different stressors.

Although there are several scales for assessing the level of anxiety in an individual, probably none are as effective as the subjective judgment of the individual by the coach. Observation of the athlete in a variety of situations will assist the coach in assessing whether the athlete needs to be calmed, left alone, or motivated.

Strange environments and experiences cause the effects of stress to be more deleterious. Becoming familiar with strange places and gradually introducing the stressor are effective techniques for reducing the deleterious effects of stress and anxiety.

Apparently, an individual can adjust to stress and increase his stress tolerance. Some research [10, 11] has indicated that the champion athlete is always at the optimum performance anxiety level (at point "B" on Figure 1) regardless of the importance of the contest. These athletes have learned to adjust and control their anxiety. Other research [12] has indicated that champion athletes have more emotion and do not have complete control of that emotion. I believe a coach should train his athletes to control anxiety and stress as carefully as he trains them for endurance. The techniques for accomplishing this objective are lacking, but progress is being made every day.

One other point should be mentioned here. Evidence indicates that as emotion increases, functioning intelligence decreases. When an athlete loses control of his emotions he should be removed from the game or contest immediately, especially if the success of the team depends upon the clear thinking of this individual. How many of you have become so enraged at the officials that you go beyond the point where you can think (perform) rationally, and thus make the wrong decisions and lose the game? Obviously, stressors also affect the coach and his decisions.

A summary of the above can best be done by again quoting Reuben Frost:

> **"Anxiety results from a summation of stressful influences and the coach must be aware of the total pattern of pressure impinging on an individual. Problems at home, successive defeats, recent failures in school or in athletics, may be already causing so much anxiety that the coach's role must be one of alleviating, rather than adding to stresses imposed."** [3]

Fear of Success

The empirical evidence for this phenomenon is somewhat lacking. However, if one reads the case studies in Beisser's book entitled *The Madness in Sports,* and analyzes Ogilvie's and Tutko's paper entitled "The Unconscious Fear of Success", it becomes apparent that for some athletes there is a real fear produced as a result of winning. Thus, we have the great athlete who suddenly chokes when victory is within his grasp.

There is considerable evidence that many individ-

uals, after attaining a lifetime goal, suddenly become very depressed and, in some instances, have attempted or succeeded in self-destruction. This is analagous to winning or being the national or world champion. What are some of the factors that create the fear of success? In the unconscious, apparently defeating an opponent is the same as beating him physically, and depending upon past experiences, may cause considerable guilt.

The fear of aggression is probably learned early in childhood. Corporal punishment or withholding love for an act of expressed aggression influences the growing child, teaching him to consider the consequences before aggressing. Thus, the child develops stop and go signals for his behavior and, as a result, is stopped from aggressing on the field of play by his sense of guilt. Winning, therefore, in the unconscious, is tantamount to destroying the opponent. Through defense mechanisms, the champion is able to deny winning. He turns his aggression upon himself, the officials, the crowd, or in some other way overcomes the unconscious concomitants of winning. This may explain why the real superchampion in some sports is introverted.[4]

According to Ogilvie and Tutko in their paper, "The Unconscious Fear of Success",[7] there are five syndromes which may prevent the highly physically skilled individual from becoming a champion.

1) He develops a growing sense of social and emotional isolation. As the athlete becomes more successful, there appears to be a form of increased resentment by his former friends. These individuals are gripped with the unconscious fear that the successful individual will outgrow the necessity of their friendship, and unconsciously they create situations which they use to confirm their convictions, and eventually they will be rejected. The sweetheart or wife is often the first one to feel this rejection. The athlete is spending more time at his sports than with his wife, and thus, when the athlete is in greatest need of some form of emotional support, he finds that it is being withheld. Further substantiation of isolation exists in the quote, "the crowd's cheers for the underdog are soon lost if one becomes the champion".

2) He develops guilt feelings about self-assertion or overt aggression. According to Ogilvie and Tutko, "almost every truly great athlete we have interviewed during the past four years, representing every major sport, has consistently emphasized that in order to be a winner you must retain the killer instinct. Each of these men had to discover for himself that winning takes an aggressive dominant spirit. Each found that he had to be emotionally free to become self-assertive and not be haunted by conscious or unconscious fears that such behavior may cause him to be socially rejected." [7]

3) He habitually rationalizes in order to protect himself from having to face the reality of true physical potential. An athlete who uses excessive rationalization dares not face the reality of his true potential. Rewards or recognition for success, for the most part, have been absent from his social training. Parents have set the standards, and any performance short of these standards has been treated as failure. An athlete, with this "hang-up" of rationalization, must avoid the conscious experience of failure, thus he develops self-deceptive ways of justifying the quality of his performance. At all cost he must avoid the test of his true potential in order to avoid failure.

4) He creates unconscious feelings of resentment as a reaction to exaggerated external demands for excellence. Once he attains the championship, he finds himself in the position of being a potential failure for the rest of his athletic life. He must live up to the expectations of not only his parents, but also the crowd. Every time he performs he is expected to attain his previous record or set a new record, thus unconscious feelings of resentment develop against these exaggerated demands.

5) He develops an unconscious fear of old traditions or old idols. Records and athletic standards become awe-inspiring to many a young athlete, and as a result he sets his motivation over a period of years in pursuit of these goals. In addition, he frequently selects the top performer as his personal idol, that is, the person he desires most to be like when he grows up. If he is to exceed the goal of his idol, he must develop an arrogance toward the old idol in order to attain the prize he has sacrificed to obtain.

A few recommendations may be in order if you, as a coach, are going to overcome the foregoing success-phobia reaction in your athletes.

Ask your athletes to think of these recommendations as ways to overcome this unique form of fear. Ogilvie and Tutko [7] have made the following recommendations:

1. Ask yourself if your devotion to your sport is a healthy one. . . . Can you play the game for the sake of the game itself? You must constantly remind yourself that playing and winning does not prove a single thing about you as a human being except that you are excellent in one sport. It does not prove that you are any more lovable, desirable, bright, worthwhile, or a success in any other area of life. . . .
2. Remember that as the individual moves up the ladder of success there will be a tendency for him to become more isolated from his peers. Often this is caused by the time requirements associated with high achievement. . . . While they were developing together, no particular threat was present, but as soon as the athlete begins to excel and outstrip his team-

mates it is possible to sense a change. . . . Should this growing feeling of isolation begin to bother your athlete, remind him that his former associates must have more frequent signs that they are still important in his life. It would even be wise to have him express in some verbal way to these friends that he is actually sensing a loss of personal closeness.

3. The young athlete who is achieving at an exceptional level must be conscious of the inclination that others will have to place him in some special category as a human being. . . . The public may demand that he conform to standards of what they expect him to be and will severely punish him should he ever deviate from the expected role of "hero". The ability to retain perspective can be increased greatly by teaching him the gentle art of laughing at himself in those areas where he falls short of greatness.
4. It is most important that he share with his wife, girl friend, or sweetheart as early as possible the nature of the sacrifices that will be a part of unusual success. If he can anticipate many of the problems and explore them in some constructive form, much of the misunderstanding will have been eliminated. . . . She should be reminded that her emotional support is fundamental to his continued success. It is my opinion that thousands of great careers in athletics have been ruined by the conflicts created by this threat and its consequent miscommunication.
5. The athlete forging to the top must be schooled to accept the reality that winning is a selfish pursuit. This will require that he develop powers of concentration that will enable him to shut out any and all distractions. . . . He must learn to put on emotional and mental blinders to control any possible distractions. Once he learns to create his own personal emotional isolation chamber he will be freer for physical excellence. Turning away momentarily from his need for personal support of friends is one of the most important emotional needs he must forsake. . . . Winning is much like death because it is something which you must do alone.

Vanek,[13] psychiatrist for the Czechoslovakia Olympic Team, has indicated that it is foolhardy to carry on a conversation with an athlete prior to his event. Each athlete is going over a mental picture of what he is going to do, and a verbal description of the skill will disrupt this mental image and perhaps cause him to perform poorly.

In summary, it should now be apparent that there are many external and internal psychological problems which will effect the athlete's performance. Aggression, anxiety, motivation, level of aspiration, self-confidence, courage, emotional state, tolerance of pain, proper state of mind, fear of failure or fear of success, and self-esteem are some of the factors related to performance.

However, I would like to warn you that you will be greatly disappointed if you believe that you can now label the psychological hang-ups of your athletes and then expect some miraculous change in their performance. Try to understand the personality of your athletes, then you will be able to strengthen and train them in combatting all of their weaknesses, not just the physical. Best of luck!

REFERENCES

1. *Dorland's Pocket Medical Dictionary*, Philadelphia: W. B. Saunders Company, 1968, p. 525.
2. Doherty, J. K.: *Modern Track and Field*, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1963, p. 199.
3. Frost, R.: *Selected Aspects of Sports Psychology*. Presented at the National Convention of AAHPER, St. Louis, Missouri, March 29, 1968, p. 4.
4. Husman, B. F.: *Sport and Personality Dynamics*, 72nd Proceedings of the National College Physical Education Association for Men, Durham, North Carolina, January 8-11, 1969, p. 63, 66.
5. Maslow, A. H., and Mittlemann, B.: *Principles of Abnormal Psychology*, New York: Harper & Brothers, 1951, p. 51.
6. Storr, A.: *Human Aggression*, New York: Atheneum, 1968, Introduction, p. 2-3.
7. Ogilvie, B. C., and Tutko, T. A.: *The Unconscious Fear of Success*. Unpublished manuscript.
8. Beisser, A. R.: *The Madness in Sports*, New York: Appleton-Century-Crofts, 1967, p. 241.
9. Ryan, D.: *What Does Psychology Have to Offer Coaches and Trainers?*" 68th Proceedings of Annual NCPEAM meeting held in Minneapolis, Minn., January 7-9, 1965, p. 36.
10. Harmon, J., and Johnson, W.: The Emotional Reactions of College Athletes, *Research Quarterly* **23**:396 (No. 4), (December 1952).
11. Kane, J. E.: The Description of Sport Types Using the 16PF, *Research in Physical Education*, (London) **1**:1, 1967.
12. Johnson, W., Hutton, D., and Johnson, G. B., Jr.: Personality Traits of Some Champion Athletes as Measured by Two Projective Tests: Rorschah and H-T-P, *Research Quarterly* **25**:484-485, (December 1954).
13. Vanek, M.: Notes from an address given at the 2nd International Congress of Sport Psychology in Washington, D. C., November 1, 1968.

your medical faculty at work

by John Sargeant
Executive Director

The Council met on Thursday, June 18, 1970, and took the following actions:

1. Waived dues of an ill member; agreed to refund one half of the annual dues paid by a member who has been ordered to Vietnam; and agreed to recommend to the House of Delegates an Emeritus Membership for another member. All of these requests came from the Montgomery County Medical Society;

2. Accepted the Budget Statement and Dedicated Fund Statement through April 30, 1970;

3. Approved the Medical Economics Committee's recommendation to raise the rates for Professional Liability coverage in Maryland as requested by the St. Paul Companies. The letter of recommendation is as follows:

The Medical Economics Committee is, among other things, charged with reviewing the Faculty sponsored Professional Liability program on an annual basis and making any recommendations involved in this regard.

At the May 5, 1970 meeting of the committee, representatives of the St. Paul Companies were present to discuss the experience of the program from its inception through December 1969. The data presented were interesting and . . . somewhat discouraging. However, when it is realized that other state programs, and rates in other communities are still considerably higher than Maryland's, we should perhaps not take this too much to heart.

As you are aware, rates for this type of insurance have been increasing by leaps and bounds. In addition, the Federal Government has expressed concern over the escalating premiums and the increasingly common knowledge that many insurers are simply refusing to underwrite this category of insurance. We are at least fortunate that a program is still available to the Faculty membership and at a rate that is less than those in other states. Maryland, currently, has the eighteenth lowest rate in the country.

After a careful examination of all the data involved in this matter, it has been ascertained that the current loss ratio is 1.189, compared to a break-even point, at which the company can make a profit, of .621. You can readily see that the company is looking seriously at this problem and is trying to determine what should be done. The only possible solution is a rate increase. No company can continue to stay in business on a loss basis

The history of the program, since its inception in 1960, is as follows:

1963		8%	decrease in premium
1965		6%	decrease in premium
1967		9%	increase in premium
1968	(March)	18.9%	increase in premium
1969		19.4%	increase in premium plus increase in basic of 25%

In each of these increases, the National Bureau change has been higher than the Maryland increase. Maryland's rates are substantially lower than the National changes and the Bureau rates for Maryland.

The Medical Economics Committee, after carefully weighing all the factors in the matter and recognizing that the company can readily withdraw from writing insurance in this field, making its availability virtually nonexistent, recommends to the Council that the changes shown (below) be approved and the State Insurance Commissioner be so advised.

It is pointed out that other changes in the policy are also being made. The following items will be required to be included by the policyholder when he purchases professional liability insurance:

Office Premises Liability
Medical Payments Liability for Office Premise Coverage
Medical Payments Liability
Personal Injury Liability

In addition, the company proposes to make available, on an optional basis, a new type of coverage called "Defendant's Reimbursement Liability." This would provide payments to the physician, for any appearances he makes in court in defense of any case filed against him, of up to $200 a day, with a limit of $5,000. This is meant to reimburse him for the time lost from his practice, money which he would not be earning because of such lost time.

The Medical Economics Committee trusts the Council will approve this proposed rate increase by the St. Paul Companies, effective July 1, 1970.

For $100,000/$300,000 coverage, physicians have to pay:

	California	Connecticut	Maryland (proposed)*	Current Maryland
Class I	573	251	163	96
Class II	912	440	287	168
Class III	1,658	1,270	489	287
Class IV	2,106	1,588	653	383
Class V	3,452	1,588	816	479

** Maryland rates through the Faculty's program only.*

4. Authorized the Medical Economics Committee to develop protocol in regard to the following two suggested projects, report to the Executive Committee, and appropriate the necessary funds to implement the projects:

a) employ an actuary or consultant to develop statistical data on professional liability actions in the state, the outcome of the cases—whether or not such actions are justified, and to collect related data

b) employ an actuary on a consulting basis to analyze the data on premium income, reserves, administrative costs, etc., provided by the St. Paul Companies to the committee, in order to ensure the recommendations made to the Council are proper;

5. Authorized the Medical Economics Committee to arrange a meeting with members of the Blue Shield Board to discuss mutual areas of concern. Representatives from the Faculty will be the Executive Director, and the chairmen of the Medical Economics, Professional Medical Services, and Peer Review committees;

6. Heard an additional progress report of the Medical Economics Committee's study of alternatives to the present system of handling professional liability cases. The report indicated that it would be impractical to adopt the method used in workmen's compensation cases. The committee is continuing to study this problem;

7. Authorized the Program and Arrangements Committee to investigate alternate sites for the 1971 Annual Meeting. The Executive Committee is now empowered to act upon the committee's recommendations;

8. Endorsed the use of the facilities of the El Conquistador Hotel in Puerto Rico for a portion of the 1971 Semiannual Session;

9. Endorsed the concept of the Maryland Consortium for Health Sciences to develop a cooperative Health Manpower training program;

10. Approved the concept of a mop-up campaign for the mass Rubella Vaccination program;

11. Heard the Peer Review Committee's report on hospital utilization and endorsed further study and a report on the committee's pilot program in this regard. This will enable the committee to investigate all aspects of the pilot program, consult with other interested groups, and seek possible sources of funds to underwrite the program;

12. Also heard from the Peer Review Committee that it has contacted the State Board of Medical Examiners in regard to testing the knowledge of examinees on proper billing for services and the quality of services offered;

13. Accepted a recommendation to support education of the public in regard to the limitations of the Medicare program. The Council also referred this suggestion to the Public Relations Committee for implementation, with the proposal that the committee develop an educational pamphlet to be used by physicians throughout the state;

14. Endorsed the action of the Executive Committee in expressing displeasure with the State Department of Health and Mental Hygiene's proposed agreement which would be signed by all providers of health care services under the Medicaid program. It also authorized the committee to take the appropriate action should the department proceed with this proposal;

15. Discussed a motion adopted by the House on Friday, April 3, 1970, which reads as follows:

> The Faculty direct its members on the Blue Shield Board to work towards elimination of arbitrary restrictions on the number of visits a physician may make in treating his patients.

(Continued next page)

The Council was advised that there was an apparent misunderstanding as the actual wording of the directive referred to is as follows:

> Please be sure to include current medical diagnosis. Medicare regulations stipulate that payments be made only where there is clear medical necessity for the services being performed. As a general guide, when requesting payments for visits in excess of four a month, be sure that the diagnosis given reflects the acute condition being treated.

The House of Delegates will be so advised at the Semiannual Session;

16. Directed that the results of the recent Membership Survey be sent to the Policy and Planning Committee for its use in making future policy recommendations; and also directed that chairmen of committees affected by certain parts of the questionnaire be notified of its results in the specific areas of concern;

17. Voted to reaffirm action taken at the March 1970 Council session to oppose any change in the Professional Corporation laws to permit use of a corporate name without the name of a physician/incorporator in the title;

18. Tabled a request from the Emotional Health Committee that would have endorsed a construction grant application for a psychiatric unit in Montgomery General Hospital;

19. Referred to the Committee on Professional Medical Services a recommendation from the Committee on Emotional Health to establish a Faculty Committee on Health Care for the Poor, with consumer representation. The Committee on Professional Medical Services is directed to prepare a study and report on the subject;

20. Supported the intent of a resolution from the Committee on Emotional Health to call on medical schools to increase their enrollment; and referred it to an appropriate Faculty committee for study and report;

21. Adopted the following resolution, as amended, proposed by the Emotional Health Committee:

> Whereas, The Medical and Chirurgical Faculty of the State of Maryland has repeatedly gone on record supporting the concept of psychiatric units in general hospitals; and
>
> Whereas, In recent years the need for such services has been recognized with resulting federal and state funds being allocated for construction of facilities on the local level; and
>
> Whereas, Public acceptance of psychiatric treatment in the general hospital is currently sufficient to allow these services in the community, be it therefore
>
> Resolved, That the Medical and Chirurgical Faculty of the State of Maryland endorses the concept that general hospitals of over 100 beds include beds for the care of psychiatric patients.

22. Approved appointment of the following committee to work with a similar liaison committee of the local AFL/CIO:

> John F. Schaefer, MD, President-elect
> Charles F. O'Donnell, MD, AMA Delegate and Blue Shield Board Member
> Lewis P. Gundry, MD, Mediation Committee Chairman
> Robert J. Thomas, MD, Council member
> Charles W. Kinzer, MD

23. Approved cosponsorship of a Workshop on Child Abuse which is being developed by the State Department of Social Services;

24. Requested Council members to submit names for possible appointment by the AMA Board of Trustees to the following AMA Committees:

> Council on National Security
> Council on Scientific Assembly
> Committee on Medicine and Religion
> Committee on Transfusion and Transplantation

It also authorized submission of the name of Russell S. Fisher, MD, for reappointment to the Committee on Transfusion and Transplantation, and other names it submitted last year for similar appointment;

25. Voted to defer action in connection with a policy decision on adoption of a Relative Value Scale since this is under study in the Professional Medical Services Committee;

26. Determined that *properly prescribed drugs* should be paid for under the Medicaid program and declined to concur with a proposal by the State Department of Health and Mental Hygiene to restrict prescriptions for certain types of drugs for certain conditions;

27. Agreed to ascertain if anything is being done on a national level with the legality of the Social Security Administration's directing of fiscal intermediaries on how to determine usual and customary fees. Authorized the Executive Committee to proceed further in challenging this matter, if it deemed it appropriate;

28. Authorized contact with the Governor and Secretary of Health and Mental Hygiene to point out that the medical profession has contributed greatly to the solvency of the Medicaid program by accepting substandard fees for many years.



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Tabulated Results of the Faculty's Survey

Although questionnaires are still dribbling in, we feel as though we now have the bulk of those that are to be returned. Out of a total membership of 3,976, 1,161 members took the time to fill in the questionnaire and return it to the Faculty offices. This is an excellent return—better than 25%—which anyone who has conducted such a survey can tell you is above average.

The results are as follows:

Please indicate your awareness of the Faculty's activities in the following areas:

	Fully Aware	Not Aware	No Opinion
1. Legislative activities on a state level, such as offering constructive legislation for the protection of the public, and opposition to legislation which infringes on the practice of medicine.	967	125	58
2. Presentation of panels to hospital medical staffs on malpractice pitfalls.	445	628	67
3. Availability of legal defense in the event of alleged professional liability, and provision of expert witnesses in this regard.	946	69	20
4. Peer review activity in connection with:			
a) Medicare & Medicaid claim forms	565	466	92
b) Utilization review activities	578	379	111
c) Adjudication of fee disputes	694	275	96
d) Determination of usual, customary and reasonable fees under Major Medical policies	623	358	82
e) Determination of ethical actions and initiation of disciplinary actions where warranted	945	143	59
f) Adjudication mechanisms between attorneys and physicians	482	445	82
5. Cooperation with various other professional groups:			
a) Bar Associations	698	261	105
b) Dental Societies	631	315	117
c) Pharmaceutical Association	631	327	116
d) Nursing Home Association	597	361	126
e) Hospital Council	724	258	98
f) Nurses Association	622	333	128
g) State and local governmental agencies	760	214	90

In the educational area the Faculty, as well as other groups, conducts continuing educational programs. Your answers to the following questions will assist us greatly in formulating plans for the future.

6. In the past year I have attended a scientific meeting of the following:	
The Medical and Chirurgical Faculty	608
The American Medical Association	219
Postgraduate Education Seminars (Med-Chi's)	281
Medical Aspects of Sports	
Viral Disease Symposium	
The 20th Century Adolescent	
My Statewide Specialty organization	594
My National Specialty organization	635
Voluntary Health organization	178
MEDIC (Medical Education's Dedicated Instructional Channel)	266
7. I read *regularly:*	
The Maryland State Medical Journal	895
The Journal of the American Medical Association	633
My specialty medical journal(s)	938
New England Journal of Medicine	288
Medical World News	610
Medical Times	364
Medical Economics	733

8. With respect to Medical Representatives of Pharmaceutical Companies, I find:

	Frequently	Occasionally	Never
a) I talk with detail men	622	427	98

b) I prefer to see such individuals:

before office hours	83
after office hours	99
during office hours	577
by appointment only	273
by request only	78
at my convenience	383
for 2 to 5 minutes	438
for 5 to 10 minutes	303
for longer than 10 minutes	44

	Frequently	Occasionally	Never
c) at exhibits at the Faculty's Annual Meeting	339	387	150

d) I believe that presentations of detail men are:

completely honest	82
usually honest	628
dishonest	17
completely adequate	54
adequate	718
inadequate	119
extremely valuable	68
valuable	652
of no value	118

e) I believe that the representatives:

are well educated	130
are adequately educated	663
are inadequately educated	109

	Yes	No
should have accreditation	502	362
should be licensed	301	532
should be required to have continuing education	786	142
should discuss one product only	177	
should discuss 1 to 2 products only	591	
should discuss all products	138	

f) Product samples:

amounts left are excessive	171
amounts left are adequate	601
amounts left are insufficient	52
should be left at request	841
not at all	20
only items discussed	97
should be increased	162
should be decreased	204
should be discontinued	88

g) Samples left are:

used for all patients	558
used for new patients only	45
used for indigent patients	423
used not at all	66

9. Use of Faculty services and facilities:

	Frequently	Rarely	Never
a) Library: I use the facilities of the library, or	97	574	457
visit library personally	52	486	480

b) Insurance Programs:
I participate in the various insurance programs *offered by the Faculty*

Professional Liability (St. Paul Companies)	647

Business Overhead Expense (St. Paul Companies)	184
Health and Accident (Hartford Insurance Co.)	399
Major Medical (Hartford Insurance Co.)	304
Life Insurance (Minnesota Mutual)	95
Blue Cross & Blue Shield	677
Med-Chi Members Retirement Plan (Keogh)	167

c) Educational Seminars I have participated in:

Office Assistant training session	184
Public Speaking training program	65

	Satisfactory	Not Satisfactory
d) Economic Matters: Negotiation with Third Party Carriers in connection with fee payments is	351	429

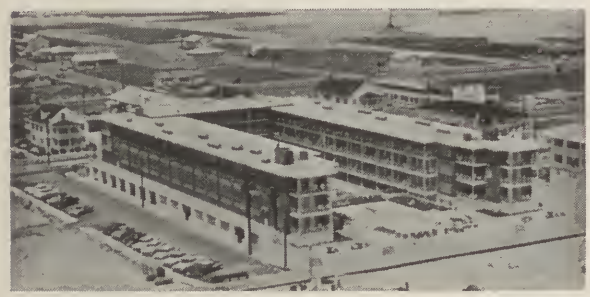
	Yes	No
The use of a trained "negotiator" would improve this current picture	503	170

	Adequate	Inadequate	Of No Value
e) Physician Placement services to communities and physicians are:	199	316	114

The general comments written at the end of the questionnaires indicated that the categories of "fully aware", "not aware" and "no opinion" have little to do with the "wishes" of the membership. Other comments were that the Med-Chi is too Baltimore oriented; the questionnaire was poorly designed; questionnaires should be sent out more often and they should be shorter.

Some of the questions, especially the one concerned with Faculty insurance programs, appear to have been misinterpreted. On the whole, however, the results of the questionnaire were satisfactory and will serve as a guide in reevaluating budget requirements, services, and the effectiveness of certain programs.

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library

Medical Library Association Conference—1970

I recently attended two important library association meetings—The Medical Library Association meeting in New Orleans in May and the Special Libraries Association meeting in Detroit in June.

On the first evening in New Orleans, the rain drenched anybody going out for dinner or a glimpse of the French Quarter. Nevertheless, Bourbon Street was teeming by ten o'clock and we, along with the other tourists, conventioneers, and high school graduates ventured out for a view of this fabulous street.

The meetings began Monday with continuing education courses on Implications of Machines in Libraries, General Biomedical Reference Tools, Human Factors in Medical Library Administration, Computers and Programming, Quantitative Measures as Management Tools, and the Literature of Dentistry.

The welcome party, "A Night in Old New Orleans", featured costumed belles and beaus of early New Orleans standing in the receiving line and greeting guests around the ballroom floor. Refreshments graced the tables and the Louisiana hospitality overflowed.

The first general session began with a welcome from Miss Mary Louise Marshall, Librarian Emeritus, Rudolph Matas Medical Library, Tulane University School of Medicine, New Orleans. Miss Marshall was also Honorary Chairman of the Conference Committee. The presidential address, "Plant a Seed", was given by Elliott H. Morse, Librarian, College of Physicians of Philadelphia. The final official and inaugural address by Donald Washburn, DDS, President, Medical Library Association, 1970-1971, was entitled "Sharpen the Ax". There was some speculation concerning the significance of the two titles.

The Medical Society Group was fortunate in having Alton Ochsner, MD, as speaker for its dinner meeting. His praise for the services of medical librarians throughout his career certainly inflated our egos.

The members attending the conference are indebted to the Abrahams Magazine Service for a sumptuous cocktail party which preceded the Tuesday evening meetings, and the Plenum Publishing Corporation for furnishing the Preservation Hall Musicians as banquet entertainers following the program on "New Orleans Funeral Music".

For details of specific meetings, watch for the proceedings in the *Bulletin of the Medical Library Association.* The proceedings of the 1969 meeting in Louisville appear in the April issue of the *Bulletin.*

A review of the Special Libraries Association meeting in Detroit will be included in September.

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Alexander, Raphael
Sources of medical information; a guide to organizations and government agencies which are sources of information in fields of medicine, health, and related areas, and to currently available pamphlets, reprints, and selected scientific papers. Arranged by subject. Edited by Raphael Alexander. New York, Exceptional Books [1969].

American Public Health Association.
Control of communicable diseases in man. Abram S. Beneson, editor. New York, 1970.

American Public Health Association. Committee on Medical Care Administration.
A guide to medical care administration. [New York] 1965-69.

American Public Health Association. Committee on Population and Public Health.
Family planning; a guide for state and local agencies. New York, 1968.

American Public Health Association. Subcommittee on Occupational Health.
Local health official's guide to occupational health. New York, 1968.

Anglesio, Enrico
The treatment of Hodgkin's disease. New York, Springer-Verlag, 1969.

Atkins, G.
Multicompartment models for biological systems. London, Methuen [1969].

Barber, Hugh R.
Are the pills safe? By Hugh R. K. Barber, Edward A. Graber, and James J. O'Rourke. Springfield, Ill., Thomas, 1969.

Barry, Hugh C.
Paget's disease on bone. Edinburgh, Livingstone, 1969.

Bowers, Warner Fremont
Emergency medical technician examination review book. Flushing, N.Y., Medical Examination Pub. Co., 1969- .

Caine, Thomas M.
The treatment of mental illness; science, faith and the therapeutic personality. By T. M. Caine and D. J. Smail. New York, International Universities Press, 1969.

Caird, Francis I.
Diabetes and the eye. By F. I. Caird, A. Pirie, and T. G. Ramsell. Oxford, Edinburgh, Blackwell Scientific, 1969.

Carrell, James A.
Disorders of articulation. By James A. Carrell. Englewood Cliffs, N.J., Prentice-Hall, 1968.

Chapman, Arthur Harry
The physician's guide to managing emotional problems. Philadelphia, Lippincott [1969].

Conference on Head Injury, Washington, 1969.
The late effects of head injury. Edited by A. Earl Walker, William F. Caveness, and Macdonald Critchley. Springfield, Ill., Thomas [c1969].

Dalrymple, Willard
Sex is for real; human sexuality and sexual responsibility. New York, McGraw-Hill [1969].

Dauer, Carl Calvin
Infectious diseases. By Carl C. Dauer, Robert F. Korns, and Leonard M. Schuman. Cambridge, Harvard University Press, 1968.

Davison, Wilburt Cornell
Davison's compleat pediatrician. Edited by Jay M. Arena, with collaboration of 15 contributors. 9th ed. Philadelphia, Lea & Febiger, 1969.

The Diagnosis of bleeding disorders. By Charles A. Owen, Jr. [and others]. 1st ed. Boston, Little, Brown [1969].

Douglas, Emily Taft
Margaret Sanger; pioneer of the future. 1st ed. New York, Holt, Rhinehart and Winston [1969, c1970].

Drugs in current use and new drugs.
1970- . Edited by Walter Modell. New York. Springer, c1970- .

Duffy, Benedict J.
Biological and medical aspects of contraception. By Benedict J. Duffy, Jr. and Sister M. Jean Wallace. Notre Dame, Ind., University of Notre Dame Press [1969].

Ellis, Franklin H.
Achalasia of the esophagus. By F. Henry Ellis, and Arthur M. Olsen. Philadelphia, Saunders, 1969.

Engelberg, Marvin Woolf
Audiological evaluation for exaggerated hearing level. Springfield, Ill., Thomas, 1970.

Flowers, Charles E.
Obstetric analgesia and anesthesia. New York, Hoeber [c1967].

Friedberg, Charles K.
Current status of drugs in cardiovascular diseases. New York, Grune and Stratton [1969].

Friedberg, Charles K.
Physical diagnosis in cardiovascular disease. New York, Grune and Stratton, 1969.

Giblett, Eloise R.
Genetic markers in human blood. Oxford, Blackwell. 1969.

Girt, J.
The multiple health screening clinic, Rotherham 1966; a social and economic assessment. By J. L. Girt, Lesley A. Hooper, and R. Ann Abel. London, HMSO. 1969.

Glassman, Jacob A.
Stomach surgery. Springfield, Ill., Thomas [1970].

Gooch, Alden S.
Clues to diagnosis in congenital heart disease. By Alden S. Gooch, Vladir Maranhao, and Harry Goldberg. Philadelphia, F. A. Davis Co., 1969.

Great teachers of surgery in the past; a collection of articles which have appeared in the *British Journal of Surgery* over the period January 1964 to January 1968. Bristol, J. Wright, 1969.

Harkins, Henry Nelson
Surgery of the stomach and duodenum. By 77 authors. Editors: Henry N. Harkins [and] Lloyd M. Nyhus. 2d ed. Boston, Little, Brown, 1969.

Havener, William H.
Atlas of diagnostic techniques and treatment of retinal detachment. By William H. Havener [and] Sallie Gloeckner. St. Louis, Mosby, 1967.

The Hypothalamus. Compiled and edited by Webb Haymaker, Evelyn Anderson, and Walle J. H. Nauta. Springfield, Ill., Thomas [1969].

Illingworth, Ronald S.
Common symptoms of disease in children. 2nd ed. Oxford, Edinburgh Blackwell Scientific, 1969.

The Individual, sex and society. Edited by Carlfred B. Broderick, and Jessie Bernard. Baltimore, Johns Hopkins Press [1969].

Jackson, Ann L.
Prevalence of selected impairments, United States, July 1963-June 1965. Washington, U.S. Health Services and Mental Health Administration, 1968.

James, J.
Scoliosis. With additional chapters by P. A. Zorab, and Ruth Wynne-Davies. Edinburgh, Livingstone, 1967.

Kilbourne, Edwin D.
Human ecology and public health. Edited by Edwin D. Kilbourne and Wilson G. Smillie. 4th ed. [New York] Macmillan [1969].

Kiser, Clyde V.
Trends and variations in fertility in the United States. [by] Clyde V. Kiser, Wilson H. Grabill [and] Arthur A. Campbell. Cambridge, Harvard University Press, 1968.

Lowenstein, John M.
Lipids. Edited by John M. Lowenstein. New York, Academic Press [1967].

Lynch, Henry T.
Dynamic genetic counseling for clinicians. Springfield, Ill., Thomas [1969].

Management of the injured patient. By 31 authors. Edited by William S. Blakemore, and William T. Fitts, Jr. New York, Hoeber [1969].

Martin, John D.
Trauma to the thorax and abdomen. Edited by J. D. Martin [and others]. Springfield, Ill., Thomas [1967].

Maryland. Commission to Study Problems of Drug Addiction.
Drug abuse study, 1969. Principal investigator: David Nurco. Project officer: Mitchell Balter. Annapolis, 1969.

Menninger Foundation Conference on the Schizophrenic Syndrome, Topeka, 1969.
The schizophrenic reactions: a critique of the concept, hospital treatment, and current research; the proceedings. Robert Cancro, editor. New York, Brunner/Mazel, 1970.

The Moment of death; a symposium. Edited by Arthur Winter. Springfield, Ill., Thomas [1969].

Nowinski, Wiktor W.
Compensatory renal hypertrophy. Edited by Wiktor W. Nowinski, and Richard J. Goss. New York, Academic Press, 1969.

Obley, Fred A.
Emphysema; a doctor's advice for patients and their families. Boston, Beacon Press, 1970.

The Pathology of memory. Edited by George A. Talland, and Nancy C. Waugh. Contributors: Raymond D. Adams and others. New York, Academic Press, 1969.

Perinatal medicine; 1st European Congress, Berlin. Edited by Peter John Huntingford, Karl Arno Hüter, and Erich Saling. Stuttgart, Thieme; New York, Academic Press, 1969.

Polson, Cyril John
Clinical toxicology. By C. J. Polson, and R. N. Tattersall. 2d ed. Philadelphia, Lippincott, 1969.

Powers, Grady Pat
Sex education; issues and directives. By G. Pat. Powers, and Wade Baskin. New York, Philosophical Library, 1969.

The Pulmonary circulation and interstitial space. Edited by Alfred P. Fishman, and Hans H. Hecht. Chicago, University of Chicago Press [1969].

Queenan, John T.
Modern management of the Rh problem. New York. Hoeber Medical Division, Harper & Row [1967].

Red Cross Scientific Symposium on Structure and Function of the Red Cell. 2d, Washington, 1969. **Red cell membrane.** Edited by G. A. Jamieson, and Tibor J. Greenwalt. Philadelphia, Lippincott [1969].

Rich, Marvin A.
Experimental leukemia. Editor: Marvin A. Rich. Amsterdam, North-Holland Publishing Co.; New York, Appleton-Century-Crofts, 1969.

Ring, Benjamin A.
The neglected cause of stroke. St. Louis, Green [1969].

Roberts, Jean
Hearing status and ear examination, findings among adults, U.S., 1960-62, Washington, U. S. Dept. of Health, Education, and Welfare, Health Services and Mental Health Administration, 1968.

Rubidomycin: a new agent against cancer. Edited by J. Bernard [and others.] New York, Springer-Verlag, 1969.

Rutgers Symposium on Drug Abuse. Rutgers University, 1968. **Drugs and youth:** Proceedings. Springfield, Ill., Thomas [1969].

Sagall, Elliott L.
The law and clinical medicine. By Elliot L. Sagall, and Barry C. Reed. Philadelphia, Lippincott [1970].

Saxon, Lauri
Congenital defects. By Lauri Saxen, and Juhani Rapola. New York, Holt, Rhinehart and Winston [1969].

Schiff, Leon
Diseases of the liver. 3d ed. Philadelphia, Lippincott [1969].

Schiffer, Mortimer
The therapeutic play group. New York, Grune & Stratton [1969].

Shapiro, Sam
Infant, perinatal, maternal and childhood mortality in the United States. By Sam Shapiro, Edward R. Schlesinger, and Robert E. L. Nesbitt. Cambridge, Harvard University Press, 1968.

Shealy, C. Norman
Spinal acuology. Springfield, Ill., Thomas, 1969.

Simmons, James E.
Psychiatric examination of children. Philadelphia, Lea & Febiger, 1969.

Stevenson, Ian
The psychiatric examination. [1st ed] Boston, Little, Brown [1969].

Strauss, Alfred A.
Immunologic resistance to carcinoma produced by electrocoagulation. Springfield, Ill., Thomas [1969].

Steele, Harold C.
High blood pressure, cholesterol, and you. By Harold C. Steele, and Charles B. Crow, Jr. Huntsville, Ala., Strode, 1969.

Symposium on Cerebral Palsy, London, 1969?
Cerebral palsy and the young child. Ed. by Susan M. Blencowe. Edinburgh, Livingstone, 1969.

Symposium on the Exocrine Glands, Philadelphia, 1968.
Exocrine glands. Editors: Stella Y. Botelho, Frank P. Brooks, and Walter B. Shelley. Philadelphia, University of Pennsylvania Press, 1969.

Tucker, William Eldon
Home treatment and posture in injury, rheumatism and osteoarthritis. By W. E. Tucker. Edinburgh, E. & S. Livingstone, 1969.

Tuberculosis. I. Tuberculosis morbidity and mortality and its control [by] Anthony M. Lowell. II. Tuberculosis infection [by] Lydia B. Edwards and Carroll E. Palmer. Cambridge, Harvard University Press, 1969.

U.S. National Center for Health Statistics.
Characteristics of persons with corrective lenses, United States, July 1965—June 1966. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 1969.

U.S. National Center for Health Statistics.
Design and methodology for a national survey of nursing homes. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, 1968.

U.S. National Center for Health Statistics.
The 1970 census and vital and health statistics. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, 1969.

U.S. Public Health Service. Division of Emergency Health Services.
Emergency health services. Selected bibliography. Rockville . . . Health Services and Mental Health Administration [1970].

Vanderbilt University, Nashville. Hospital.
Diet manual. 2d ed. Nashville, Vanderbilt University Press, 1969.

Von Hippel, Arndt
Chest tubes and chest bottles. Springfield, Ill., Thomas [1970].

Wachtel, Erica G.
Exfoliative cytology in gynaecological practice. 2d ed. New York, Appleton-Century-Crofts [c1969].

Weibel, Jorge
Atlas of arteriography in occlusive cerebrovascular disease. By Jorge Weibel, and William S. Fields. Philadelphia, Saunders; Stuttgart, Thieme, 1969.

Wilson, Dorothy C.
Lone woman; the story of Elizabeth Blackwell, the first woman doctor. 1st ed., Boston, Little, Brown [1970].

Wilson, John L.
Handbook of surgery. Edited by John L. Wilson. 4th ed. Los Altos, Calif., Lange Medical Publications, 1969.

The Year book of plastic and reconstructive surgery, 1970- . Chicago, Year Book Medical Pub., 1970- .

Zweng, H. Christian
Laser photocoagulation and retinal angiography; with current concepts in retinal and choroidal diseases. By H. C. Zweng, Hunter L. Little, and Robert R. Peabody. Saint Louis, C. V. Mosby, 1969.

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NEIL SOLOMON, MD, PhD, SECRETARY

Maryland State department of health and mental hygiene

The National Scene

The cost of patient services in state- and county-operated mental hospitals in the United States in 1969 was nearly $1.75 billion.* This figure exceeded the total budget of Maryland and all but a few populous states. It reflected an increase of $162 million, or 10.2%, over the previous year's comparable figure. In Maryland and in most states, expenditures have risen every year in the last decade and have doubled since 1959.

Daily costs per patient have risen proportionally faster than total expenditures, because of the decline in the average number of persons hospitalized. Since 1959, this figure has decreased 3.5% a year nationwide (from 542,135 to 378,633) and 1.9% in Maryland (from 8,952 to 7,451). Because of these two interrelated factors, the average daily cost of caring for one patient in all states rose 11.4% annually during this ten-year period (from $4.29 to $12.59). Maryland, with a reported daily per patient expenditure of $12.50, has had an annual increase of 10.3% since the $4.69 noted in 1959. The state currently ranks 28th, between the high of $38.93 for Alaska and the low of $5.40 for Mississippi. It ranked 16th in 1959.

FISCAL YEAR	AVERAGE SIZE OF PATIENT POPULATION	NET LIVE RELEASES	TOTAL EXPENDITURES	EXPENDITURE PER NET RELEASE
1959	542,135	176,411	$ 849,493,595	$4,815.42
1964	496,661	268,616	1,144,024,206	4,258.96
1966	460,910	308,636	1,300,380,295	4,213.31
1968	412,818	351,461	1,577,631,758	4,488.78
1969	378,633	374,383	1,739,293,258	4,645.75
PERCENT CHANGE (1969 vs. 1959)	—30.2	+112.2	+104.7	—4.5

While these data reflect rising personnel-patient ratios, the current emphasis on psychopharmacology, and other innovations in treatment services, they are primarily related to the rapidly increasing patient turnover. This turnover results from shortened periods of hospitalization for all categories of new admissions and the transfer of long-term patients to nursing homes. In Maryland, as elsewhere, more patients are treated each year even though the average population size is decreasing and réleases have more than doubled since 1959. In fact, this latter rise has been so large that the average expenditure required to produce one net release is now less than it was ten years ago.

If present trends continue, the average daily cost per patient must be expected to rise 10% or more a year even though the average total cost of each episode declines further. The only alternative to continuing, uninterrupted increases in state psychiatric hospital expenditures is to drastically reduce the size of the patient population by 1) providing community-centered programs as an alternative to hospitalization, 2) further decreasing the average length of hospitalization, 3) transferring chronic, custodial patients to nursing home type facilities, and 4) developing and expanding after-care services for released patients. Maryland is now seeking to accomplish this through a closely coordinated and centrally directed program offering a variety of community and hospital services to the mentally disturbed and through the implementation of current and new concepts for the prevention of mental illness.

** Office of Biometrics, National Institute of Mental Health, Provisional Patient Movement And Administrative Data-State And County Mental Hospitals-United States-July 1, 1968-June 30, 1969.*

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Smoking and Health

As the years pass, the evidence of the close relationship between cigarette smoking and such respiratory ills as emphysema, chronic bronchitis, and lung cancer continues to accumulate. It is particularly strong in relation to lung cancer. In Baltimore city, from 1950 on, the trend has been upward, from 186 deaths in 1950 or 19.6 per 100,000 population, to 451 deaths in 1969 or a rate of 49.7 per 100,000 population.

At the same time, the death rate for chronic bronchitis and emphysema—although much lower than the rate for lung cancer—almost doubled, with 8.8 deaths per 100,000 in 1960 and 1961 compared to 17.1 for 1968 and 1969. In addition, emphysema stands second among disability claims, according to officials at the Social Security Administration.

A look at lung cancer deaths in the age group from 25 to 44 years shows a 94.7% change from 5.7 per 100,000 population in 1960 and 1961 to 11.1 for 1968 and 1969. An increase of 21.9% was manifested in the same period for the 45 to 64 year age group and an almost 50% increase for those 65 years and older.

The 1969 statistics show the greatest number of deaths in the most productive years. From age 40 to age 75, there were 387 deaths out of a total of 451 cases for the year. Lung cancer today in Baltimore leads all cancer deaths. It is followed by cancer of the intestine with 205 deaths in 1969 and cancer of the breast with 157 fatalities last year.

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tuberculosis

The Public Health Tuberculosis Clinic— Its Place in Comprehensive Health Care

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The public health tuberculosis clinic and the future of tuberculosis control are caught in the present turmoil surrounding the organization and delivery of medical care in the United States. To understand the importance of the tuberculosis clinic, much can be learned from the past.

After the bacterium causing the disease was identified, Biggs [1] called for free dispensaries to be the focal point of tuberculosis control in New York. All ambulatory patients were to be provided with constant medical supervision, free medicine, and free food. Flick and Francine, turn-of-the-century leaders, emphasized preventive outpatient procedures while developing the Phipps Institute Dispensary in Philadelphia.[2, 3] Joseph H. Pratt, MD, of the Massachusetts General Hospital, culminated early outpatient efforts with his intensive home care program.[4, 5]

During the first quarter of the century, the practice of medicine began to shift from the bedside to the office.[6] Simultaneously, the number and scope of general medical clinics and outpatient departments increased from 150 in 1900 to 5,000 in 1925.[6, 7] In 1905, the newly formed National Association for the Study and Prevention of Tuberculosis emphasized the use of outpatient facilities for the protection from and control of tuberculosis. By 1915 these facilities had grown in number from 20 to more than 500.

In sharp contrast to the general clinics, which were outgrowths of charity, the tuberculosis dispensaries arose from a public health concern for centers for treatment, prevention, and health education. However, the declining rate of disease, the outbreak of World War I, and the isolation of many tuberculosis clinics from general medical outpatient services combined to reduce this voluntary endeavor.[8] Moreover, the major trend was toward hospitalizing patients with active tuberculosis because of the increasing belief in the value of prolonged bed rest. Hospital treatment of tuberculosis was dominant in the 1930's, and by the early 1940's, outpatient clinics, except for the pneumothorax clinics, were no longer important in the treatment of tuberculosis. The pendulum had swung from home and clinic to hospital in 50 years.[9]

Then, as knowledge of the natural history of tuberculosis increased and new forms of therapy became available, the pendulum began to swing back. With the discovery of streptomycin in 1944, PAS in 1946, and isoniazid in 1951, a debate started at the walls of the sanatorium. The studies of Wier,[10] D'Esopo,[11] Hirsch,[12] and Robins [13] demonstrated that patients could be treated effectively on an ambulatory outpatient basis. The public, accustomed to dramatic breakthroughs, believed that the problem of tuberculosis was solved but, unfortunately, tuberculosis clinics were unprepared for this responsibility.[14] Therefore, many patients turned to private physicians for care to avoid hospitalization.[15] McDermott noted that this change was unprecedented and unplanned, and he warned that widespread harm could arise from the injudicious use of chemotherapy by general phy-

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sicians who had had no experience with the day-to-day decisions necessary in the treatment of pulmonary tuberculosis.[16]

In the face of the complex problems raised by the trend to home care by private practitioners, the need for long-term therapy, the lack of adequate clinics, and the rising concentration of an otherwise declining disease in the aged, the poor, and the uncooperative, the Arden House Conference was held in 1959.[17] The result was the landmark recommendation that state and local health authorities assume responsibility for ensuring the adequate treatment and rehabilitation of all patients with tuberculosis. In 1963, a Task Force reported to the Surgeon General the need for communities to build up clinic-centered tuberculosis control programs.[18] Thus, by 1967, under the stimulus of federal grants, tuberculosis clinics were made the primary responsibility of public health departments and, once again, had become the focal point for diagnosis, treatment, and control of tuberculosis.

However, they now face this responsibility in an era of increasing public apathy, a rapidly diminishing supply of specialists, a localization of the disease in poverty areas, and problems of financing. In their earlier years of dominance, tuberculosis clinics were well financed, but during the era of the sanatoriums the funds passed to these institutions and have remained there. The clinics now depend on federal funding for growth, and, occasionally, for their very existence. Worse, the clinics' problems are too often compounded by a long-standing lack of communication with the institutional system, and not infrequently by direct opposition from institution-based personnel.

Moreover, new clouds are gathering. We are in a decade of tumultuous change in the provision of medical care. Titles 18 and 19 eliminate the financial lure of free tuberculosis clinics, and might return to private practitioners that high-risk population that has characteristically been the responsibility of agencies. The trend to hospitalize tuberculosis patients in general community hospitals would support this movement. Further, Public Law 89-749, which demands that state governments play a larger role in the distribution of federal monies to large municipalities, combined with a cutback in federal funds, may effectively divert previously earmarked monies into other programs. This is further accentuated by the recognition of medical care as a right in the United States and by the resulting burgeoning of health care programs.

It might well be asked whether we need special tuberculosis clinics. The increasing emphasis on comprehensive health care appears to be in direct opposition to semi-independent tuberculosis clinics. The trend toward group practices and subspecialization of physicians strengthens the proposal of Robins [19] that tuberculosis clinics be incorporated into hospital-based chest clinics. However, if we have learned anything from history, it is that the public health tuberculosis clinics must continue to exist. This conclusion is supported by the current therapeutic situation, which requires facilities for short-term hospitalization and long-term outpatient follow-up, as well as the continued need for protecting the public health through the identification of active cases and the management of contacts. These may demand legal action at times.

In the past, both the sanatoriums and the general providers of medical care, including private practitioners, have had grave difficulties in fulfilling these requirements. The inpatient institution maintains its value by providing a site for isolation, close observation for reactions to medication, and education of patients. If incorporated into the total treatment of the patient, it can provide an opportunity to evaluate the reliability of the patient, as well as the social complex in which he will receive the bulk of his treatment. However, without adequate outpatient follow-up, the period of institutionalization, whether in a general hospital or sanatorium, has litle value.

The providers of ambulatory care face another problem. Even with the best intentions of the physicians and staff, the actual responsibility for care rests with the patient. In tuberculosis control, the responsibility for care rests with the clinic. Few outpatient departments or group practices, much less private physicians, have the capability of recalling patients, studying their reliability, or pursuing their contacts.

Next, the diminishing supply of tuberculosis specialists is intimately related to the overall problem. With the decision of Congress to discontinue assigning two-year medical officers from the Tuberculosis Branch of the National Communicable Disease Center to states and municipalities, a potential source of specialists was lost. The danger of the alternative —rotation of general medical residents through clinics based in health departments—is that later, as private practitioners, they might attempt to treat tuberculous patients in their offices, thus repeating the problems of 1953 through 1959.

It seems inescapable that the public health tuberculosis clinic is the only way of meeting all these needs. It must become the tuberculosis consultant and referral specialist for the entire medical community. This is true regardless of whether the patient is receiving his general medical care from the individual private practitioner (whether on a Title 18 or 19 or private pay basis), through prepaid or fee-for-service group practice, or through municipal health facilities. The clinic is the best way to husband the meager resources of personnel and money and the only way to fix responsibility on the providers of service rather than on the recipients.

To ensure the success of the clinics, a number of

steps should be taken. First, all groups working in the field of tuberculosis (voluntary and official, state and local, sanatoriums, and medical schools) must cooperate so that the best care will be found in these clinics. The clinics should be so effective and attractive that physicians will refer patients to them freely and that patients will readily accept the referrals.

Second, we need to ensure a supply of well-trained personnel. This can best be accomplished by incorporating some participation in public health tuberculosis clinics into all pulmonary fellowships under standards set by the professional societies, the medical schools, and public health specialists. The realistic use of federal money for training in tuberculosis could make this feasible.

Finally, let us not be diverted again by new and untried programs, nor return to methods that already have failed. We must insist that those responsible for the allotment of funds through federal grants, state planning agencies, and regional programs continue to recognize the utility and necessity of public-health-based tuberculosis clinics.

REFERENCES

1. Biggs, H.: First Annual Report of the Henry Phipps Institute for the Study, Treatment, and Prevention of Tuberculosis, 1:169, 1903.
2. Flick, L. F.: First Annual Report of the Henry Phipps Institute for the Study, Treatment, and Prevention of Tuberculosis, University of Pennsylvania, Henry Phipps Institute, 1:3, 1903.
3. Francine, A. P.: Pulmonary Tuberculosis, Its Modern and Specialized Treatment, J. B. Lippincott Company, Philadelphia and London, 1906.
4. Pratt, J. H.: *Boston Med Surg J* **154**:210, 1906.
5. Pratt, J. H.: *JAMA* **44**:755, 1907.
6. Davis, M. M.: Clinics, Hospitals, and Health Centers, ed. 1, Harper and Brothers, New York and London, 1927.
7. Davis, M. M. Jr., and Warner, A. R.: Dispensaries, Their Management and Development, The Macmillan Company, New York, 1918.
8. Association of Tuberculosis Clinics of the City of New York: Dispensary Control of Tuberculosis, Sixteenth Annual Report, **Yearbook, 1924.**
9. Jacobs, P. P.: The Control of Tuberculosis in the United States, National Tuberculosis Association, New York, 1940.
10. Wier, J. A., et al: Trans. 15th Conf. on Chemother. Tuberc., VA—Army & Navy, 1956, p. 60.
11. D'Esopo, N. D., Rodman, M., and Delabarre, E. M. Jr.: Trans. 15th Conf. on Chemother. Tuberc., VA—Army & Navy, 1956, p. 60.
12. Hirsch, J. G., et al: *Amer Rev Tuberc* **75**:359, 1957.
13. Robins, A. B., et al: *Amer Rev Tuberc* **75**:41, 1957.
14. Bloomquist, E. T.: *Amer J Public Health* **46**:149, 1956.
15. Hetherington, H. W., and Eshlaman, F. W.: Tuberculosis: Prevention and Control, G. P. Putman's Sons, New York, 1958.
16. McDermott, W.: *J Chronic Dis* **2**:234, 1955.
17. U. S. Department of Health, Education, and Welfare: The Arden House Conference on Tuberculosis, Harrison, New York, November 29 to December 2, 1959, Public Health Service, Communicable Disease Center, Tuberculosis Program.
18. U. S. Department of Health, Education, and Welfare: The Future of Tuberculosis Control, A Report to the Surgeon General of the Public Health Service by a Task Force on Tuberculosis Control, Public Health Service Publication No. 1119, December, 1963.

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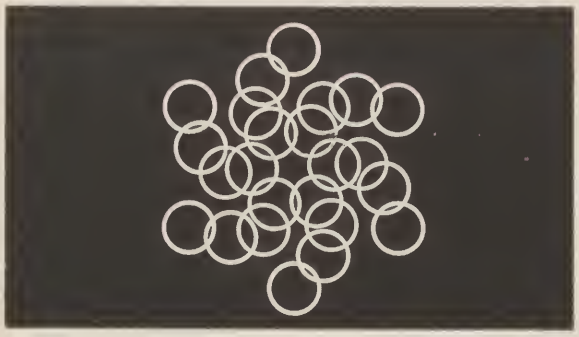


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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

The Alcoholism Counselor in a General Hospital

CLARENCE W. HURLEY, JR.
Alcoholism Counselor
Mercy Hospital
Baltimore

Mercy Hospital is a "downtown" hospital. Its catchment area includes the "skidrow" sections of Baltimore, where there is a recognized need for assistance with alcoholics. The need for an alcoholism counselor, a nonprofessional but trained person in a general hospital, is a real and practical one. On February 9, 1970, I was employed as full-time alcoholism counselor at Mercy Hospital.

My immediate problem concerned the homeless, indigent alcoholics, and how to deal with them. These patients can be disruptive to a hospital's routine and disturbing to other patients. Some of them are loud and garrulous, and use abusive language. Others are withdrawn, disoriented, and difficult to communicate with. However, all these patients want and need help of some kind. My job as counselor is to provide that help and assistance when possible and, at the same time, to relieve the professional staff and other hospital personnel of the expensive and time-consuming task of serving the alcoholics.

The inpatients in the wards are one of my major concerns. Many of these patients are alcoholics or heavy drinkers with serious medical problems, and must be advised about the dangers of continued drinking. They are advised to come to me for counseling at the time scheduled for regular outpatient appointments. Some of these alcoholic patients need further treatment in a state hospital; others are referred to an alcoholism clinic, AA, or other agencies.

The expense of treating the alcoholic inpatient with other accompanying illnesses is high. The cost, on the average, is $82 a day, or approximately $2,000 for a 24-day hospital stay. The cost would be justified if the patient were permanently cured. But this is not the case if the patient continues to drink and returns to the hospital more seriously ill than before. It is my responsibility to try and break this cycle.

Patients are referred to me from many departments within the hospital. To establish the various sources of referrals, I kept records of every patient that I interviewed. By April 6, 1970, I had interviewed 50 patients.

Twenty-one patients were referred to me from the inpatient wards, 11 from the accident room-emergency department, 10 were "walk-ins" (not medical patients), 2 were employees, and 6 came from other sources.

This group of patients consisted of 48 men and 2 women.

According to age, 1 patient was under 25, 3 were 25 to 35, 8 were 35 to 45, 32 were 45 to 55, 5 were 55 to 65, and 1 was over 65.

Professionally, only 7 were skilled or semiskilled; 42 were laborers, part-time workers, or were unemployed; and 1 received social security benefits.

According to their residence status, 28 of the patients were homeless, 10 lived in single rooms, 1 lived in an apartment, 1 owned his own home, and 10 lived with a relative. Only 2 of the 50 patients were married and lived with their spouses; the rest were single, separated, divorced, or widowed.

It is too early to report on the success of my service. However, progress is being made in helping these alcoholics. Chronic alcoholics respond to a counselor's intelligent, understanding attitude, and this is what I try to give them. Each individual is treated as a distinct person with his own particular alcohol problem. I believe that my attitude toward all alcoholics, and my personal philosophy that everyone has another chance, will help to make this program a success in the future.



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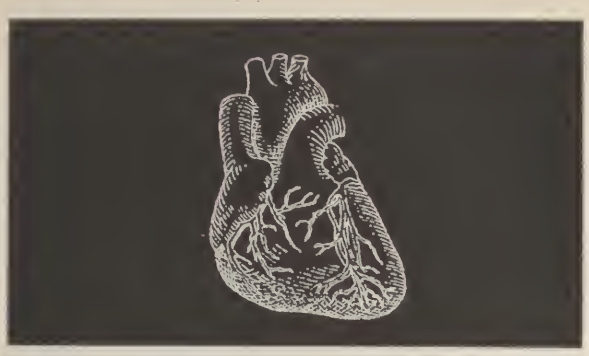
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A Service of the Heart Association of Maryland

the heart page

Dietary Salt (Sodium Chloride) Intake and Arterial Hypertension: (Part) I

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The possible association between salt intake and arterial hypertension has been a subject for discussion for a number of years. It is generally accepted that the level of blood pressure is determined by many factors, both constitutional and environmental. Lewis Dahl [1] found that habitual salt intake may be one important factor.

The Pathogenesis of Essential Hypertension could be expressed in a formula as follows:

A + B → Hypertension
A = Genetic Factor
B = Questionable dietary sodium
Decreased cadmium, decreased potassium
Cadmium/Zinc ratio
Water hardness (or lack of)
Tension (emotion)
Race
Obesity

Certain observations are worth noting as far as population groups are concerned. A number of people have observed a reduced incidence of hypertension in primitive races, with virtual absence among groups differing as widely in environment as Greenland Eskimos, Australian Aborigines, mountainous Chinese tribes, and Cuna Indians of Panama. Generally, it has been felt that the absence of hypertension among such people is due to their simple mode of living which is devoid of the strains associated with modern living. However, these primitive groups are not as strain free as one would expect because of the scarcity of the necessities for survival, the rigorous climates, sudden warfare, and the pressures of their social taboos.

Worth mentioning are some of the experimental data that seem to support the significance of salt in the diet and hypertensive disease. Studies of rats show that hypertension can be produced by feeding, or infusing, large amounts of salt, but the failure rate was 20% to 30%. Weller, of the University of Michigan, however, was unable to produce experimental hypertension after feeding rats salt for several years. Infusion of 1% saline to dogs produced hypertension which continued after reducing the sodium infusion. A certain number of these animals, and especially the rats, will go on to have a hypertensive disease process that seems to be quite similar, if not identical, to human essential hypertension.[2] In the dog experiments, there was not only an increase in blood pressure, but also an increase in cardiac output, stroke volume, and eventually an increase in peripheral resistance.

The experimental data also have been extended into the possible effects of other ions on hypertension produced by sodium. An interaction between sodium and potassium has been noted.[3, 4] There seemed to be a lower blood pressure response if the animals were fed an excess amount of potassium. An interaction between sodium and calcium also has been suggested, for the more calcium excreted

the more sodium was excreted. Rats on low calcium diets and fed normal saline developed slight hypertension, whereas those on normal calcium diets did not develop hypertension to the same degree, even when fed normal saline.

Hypertension may be more prevalent in populations in which there is an obligatory low calcium intake. In certain poor socioeconomic groups, in which there is a low intake of milk products, a possible relationship may exist in the high incidence of hypertension to low calcium intake. This may be particularly pertinent to the black populations of the South.

From the clinical point of view, what can one conclude about sodium in the diet and hypertensive disease? As early as 1929, it was postulated that low salt diet seemed to be found fairly frequently with normal blood pressure and the converse was likewise true. The observation that natural foods usually contained an increased amount of potassium and a decreased amount of sodium led to the conclusion that this may explain the low incidence of hypertension in the more primitive areas where natural food is consumed in fairly large quantities. The dietary habits of several populations around the world have lent much support to the belief that high salt intake can definitely be correlated with arterial hypertension.[3] The average salt intake of the Alaskan Eskimo is approximately 4 gm a day with a range between 1 gm and 10 gm a day. The Marshall Islanders of the Pacific area consumed an average of 7 gm of salt a day with a range of 1.5 gm to 13 gm a day. In the United States, in Brookhaven where Dahl's studies were conducted,[5] the salt intake was approximately 10 gm a day with a range between 4 gm and 24 gm a day. Most people quote the average American sodium intake as being between 10 gm and 15 gm a day as indicated by the urinary losses which tend to reflect the minimal sodium intake. In Japan, in studies done between 1954 and 1958, the average sodium intake was 14 gm a day with a range between 4 gm and 29 gm a day, and the incidence of hypertensive disease is also considerably higher. This, again, lends support to the sodium theory of arterial hypertension. In the primitive tribes, as mentioned earlier, in which there is a very low level of hypertension, the intake of sodium is between 1 gm to 2 gm a day, which is extremely low. Another very interesting population study is recorded in the *New England Journal of Medicine,* September 5, 1968.[6] The populations were of the same broad ethnic origin. One was the population of Pukapuka in northern Cooke Island. These people live in a below-subsistence-level economy with a diet composed chiefly of coconut and fish. The other group was a sample of adults who lived in the town of Abarua in southern Cooke Island for at least ten years. These people had a more advanced economy and had ready access to a varied diet including some canned goods. The conclusions of these studies suggest considerable differences between the two populations in blood pressures, which seems to confirm the work of other investigators. The differences were not attributable merely to the relationship of blood pressure to the body weight, height, and other factors, as these were allowed for. There was no question that there was an habitual salt intake that was much higher in Abarua than in Pukapuka. The surveys showed that the salt intake in Pukapuka was 50 to 70 milli equivalents a day and 120 to 140 in Abarua. Similarly, they found a positive correlation, that was statistically significant, between the blood pressures in the high sodium and the low sodium groups.

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DOUGLAS G. CARROLL, MD, EDITOR

Rehabilitation Needs of Patients with Spinal Cord Injuries

In a report [1] several years ago on spinal cord injuries, I made a plea that a center for paraplegics be established in Maryland. At that time, I had in mind as a model the National Paraplegic Center at Stoke-Mandeville in England where nearly all spinal cord injuries in Great Britain are treated. Such a center in Maryland would accept all acute spinal cord injuries at the earliest possible moment from all over the state for emergency and early care. This is a major problem at the present time because no one hospital accumulates enough experience or has enough trained personnel to care for this very specialized problem. The centralization of such trained personnel in a single hospital should greatly improve the early care.

The early care would be defined as six months to a year following injury. Recent advances in stabilization of the neck ("Halo" neck apparatus), use of ilio-conduit bladders, and Stryker pads could all be evaluated and put to optimal use in a center where experienced people were working. A major effort at emotional and motivational aspects would be required both early and late in the course of treatment.

A second stage would be beginning both physical and vocational reeducation. Increasing the educational level of patients with spinal cord injuries is most important for the majority of patients. In addition, there might be vocational shop training, a sheltered workshop, or other demonstration to the patient that he can be at least partially financially self-supporting.

The third stage would be placement of the patient. Some would become vocationally independent. Others would be placed in a nursing home, hopefully a special nursing home for young people, with activities and continuing educational efforts. Some would return to their homes. All patients would need to be followed permanently from the medical point of view, probably at the central hospital, for bladder care, treatment of ulcers, and the intermittent hospitalization so characteristic of patients with spinal cord injuries.

When this plan was suggested, there were no funds available for such a project. With the development of Regional Medical Care (stroke, heart disease, cancer program) it may be possible to establish such a unit to meet this very difficult problem, such as the Southwest Regional System for Treatment of Spinal Injury in Arizona.

A first step in such an undertaking is a definition of the problem: How many patients might benefit from such a program? What benefits not now available might be expected? What would it cost? Two recent articles, one from a rehabilitation center and the other from the National Paraplegic Foundation, present information on the problems and results of caring for patients with spinal cord injuries.

* * * * *

Siegel [2] reports on 143 quadraplegics discharged from the Institute of Rehabilitation Medicine, New York University, between 1962 and 1967. One hundred and thirty-two patients were quadraplegic as the result of trauma, and 11 as a result of poliomyelitis. Of the 131 patients from whom data were obtained, 34% were in competitive employment,

47% were in school, 2% were homemakers, and 17% were unemployed. Thus, of the total group, 81% (including those actually employed and those in school) were potentially self-supporting.

* * * * *

The National Paraplegic Foundation has published an excellent study [3] of the rehabilitation needs of the spinal cord injured and disabled. The ultimate aim of the project was to demonstrate methods of coordination and organization to improve the availability of services to paraplegics. Such a study is long overdue. Although veterans with paraplegia have been given excellent care since World War II, civilians suffering similar accidents have not.

This study attempted to find all paraplegics in Arkansas, Indiana, and New Jersey, to identify their needs, to evaluate the services and facilities available to them, and to formulate plans through which the local community and rehabilitation agencies might improve treatment.

Paraplegia was defined as paralysis of the lower extremities resulting from injury or disease involving the spinal cord; quadriplegia was defined as paralysis of the lower and upper extremities resulting from injury or disease involving the spinal cord at the cervical level. Cases were located through the Veterans Administration, rehabilitation services, hospitals, county health officers, the National Paraplegic Foundation, Public Health Nurses, nursing homes, and other interested people. It is obvious that such a method of obtaining a list of patients is not completely satisfactory. Probably patients with prolonged disability, who were on a number of lists, were selected, rather than the paraplegics of shorter duration, such as those with paraplegia caused by metastases, and infant paraplegics. A total of 1,984 questionnaires were sent to patients in the three states. Six hundred and thirty (32%) returned the questionnaire. Incomplete or unreadable questionnaires were eliminated. In all, 566 questionnaires were analyzed.

Incidence

The information from Arkansas was most complete, because all rehabilitation services are coordinated by the State Department of Education. A census of these disabilities, taken in Arkansas in 1958, showed approximately five spinal cord injured and disabled persons per 10,000 population. Using the same proportion to the total population of the United States (190,000,000) would give a national estimate of about 95,000 paraplegics and quadriplegics. If Maryland had 2% of the total population in the United States, there should be about 2,000 paraplegics and quadriplegics.

Fifty-seven percent of those answering the questionnaires were paraplegics; approximately three quarters of all patients were men. Forty-two percent of the study group were veterans, and only 35 (11% of the veterans) were disabled from combat injuries. The educational level of the cord injury group averaged about a year greater than the general population in each of the three states. Approximately half of those with spinal cord injuries had been married; 73.8% of the paraplegics, and 70.1% of the quadriplegics had one child or more. Divorces were relatively uncommon among both groups.

Automobile accidents accounted for 25% of the cases, poliomyelitis 16%, disseminated sclerosis 7%, falls 7%, combat injuries 6%, sports 6%, gunshot (not service-connected) 5%, and industrial accidents 4%. This accounts for only 76% of the total cases. Relatively few patients with congenital abnormalities of the cord were located.

Hospitalization and Rehabilitation

The average initial hospital admission was seven months for both paraplegics and quadriplegics. The average length of disability of the entire sample was 11.25 years. Only 29% indicated a current need for hospital aid. This was probably related to the length of disability. Most of the patients who reported a need for services desired more physical therapy.

The patients believed that an adequately trained staff was the most important need in hospitals. Psychological and vocational counseling and physical therapy were specialties most frequently believed inadequate. Only 27% had attended a rehabilitation center for treatment. Fifty-six percent of the patients who attended rehabilitation centers accomplished goals which they had set for themselves. This is a surprisingly high figure. There is no estimate from those who did not attend rehabilitation centers.

Paraplegics expressed interest in obtaining more vocational counseling and training. Quadriplegics expressed a need for further physical therapy. A study was made of ten paraplegics and eight quadriplegics from Arkansas who reported a need for rehabilitation center services. Eight of these had received previous services and it was felt that five of them could not profit from additional services because of motivation problems. Four of these people were paraplegics and, in all instances except one, the rehabilitation counselor felt that the receipt of monetary compensation (social security disability benefits) negatively influenced the desire for further service. Discontinuity of services in transfer from hospitals slowed physical progress and extinguished motivation for social-vocational rehabilita-

tion. Civilian hospitals have failed to recognize the value of continuous integrated delivery of services.

Employment Status

Excluding patients currently hospitalized and students and housewives, 41% of the total group of civilians were employed—47% of the paraplegics and 33% of the quadriplegics. Most of these were self-employed in businesses they had started themselves. Only 12% had been placed by rehabilitation counselors. Those employed averaged over two years more education than those unemployed. Of those who had attended or graduated from college, 76% were employed, in contrast to 36% who had attended or graduated from elementary school only. These figures suggest that unemployment is uncommon for the disabled who possess a college education.

There was a prolonged period before the patient could face the requirements of normal living again. Very few civilians who had been disabled in the last five years were employed. Only 39% of paraplegics and 44% of quadriplegics who had attended rehabilitation centers were employed. Individual drive and motivation are major factors in returning to employment.

Three fifths of those not working stated that their physical condition prohibited employment. Persistent pain, urinary tract infections, and recurrent muscle spasms were among the major symptoms restricting employment. Financial compensation from employment was generally not sufficient to motivate them to compete with able-bodied people for work.

In summary, a number of important factors will influence whether the patient with a spinal cord injury becomes employed. First, the extent of the paralysis is of great but not absolute importance. The speed of recovery will depend on the patient's prior psychological makeup, his previous work level, and his educational background. His success with rehabilitation, in his own eyes, is of importance. The job opportunities in the community and the attitude of employers are of great importance as is the financial return from the work.

It seems clear, however, that educational level and individual motivation are the major factors in making a successful adjustment to spinal cord injury. Assuming adequate basic medical care, the major task of the rehabilitation team is to find ways to educate and motivate patients.

Final Conclusions and Recommendations

There is an increasing number of traumatic spinal cord injuries. The rehabilitation services available are very narrow. The number of people trained to care for these people in medical, nursing, and paramedical specialties is far too small. Coordination of local facilities is a major need and would result in improved treatment.

The report recommends that state divisions of vocational rehabilitation assist in the establishment of rehabilitation councils whose purpose would be to explore the present patterns of service offered spinal cord injuries, determine what their future needs might be, suggest methods for improving and coordinating service programs, and attempt to facilitate communications among various agencies so that they might better understand their roles and responsibilities.

* * * * *

This report suffers from two major deficiencies. First, only 32% of the questionnaires were returned. Some of these had to be eliminated so that the sample was very small. There is every reason to believe that the patients who returned questionnaires were significantly different from those who did not return questionnaires. The exact difference, of course, cannot be pinpointed, but it might be expected that those who were illiterate or very poorly educated were not represented. The design of the search for patients would tend to eliminate those who had paraplegia as a result of neoplasms or congenital defects, since they are unlikely to live long enough to be recorded in such a survey. These patients constitute an important group suffering spinal cord disabilities, and much can be done to help them.

A second major problem with this study is that the patients themselves judged whether or not their rehabilitation needs had been met. This method of evaluation may be more a measure of the patient's frustration than of the quality of rehabilitation facilities.

Nevertheless, this is the best, if not the only, study of the socioeconomic results of treatment of patients with spinal cord diseases and injuries. It is sufficiently large to identify the major needs which are not being met.

* * * * *

Recommendations for Improvement of Care of the Spinal Cord Injured in Maryland

1. It is clear that a survey of the situation of the spinal cord injured should be made in Maryland. Data on the number of cases, their present location, the available facilities, their employment status, unmet needs, and costs should be collected.

2. This study should be performed by a permanent official committee representing all those interested in the problem. In Arkansas, the State Department of Education has responsibility for such information and planning. The National Paraplegic Foundation has taken initiative in the report summarized above. The Regional Medical Program is another possible organization which might undertake such a study.
   Studies by individuals and hospitals have little impact because the problem extends beyond any single hospital and requires support of educational, rehabilitation, long-term care facilities, and vocational resources. Interhospital responsibilities and the private practice of medicine are involved in the problem.
3. The increasing number of patients with severe head injuries and brain damage secondary to anoxia should be investigated as a possible related problem to spinal cord injuries.
4. A spinal cord injury registry should be started in Maryland.

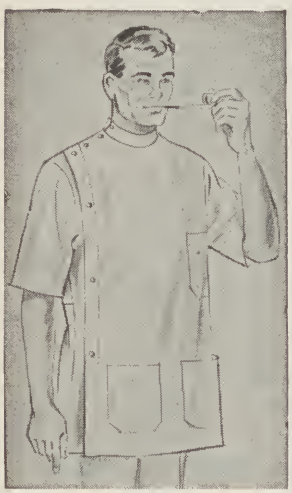
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1. Kurtz, J., and Carroll, D.: Management of Severe Injury of Spinal Cord in Civilians. *Arch Physical Med and Rehab* **43**: 494, 1962.
2. Siegel, M. S.: The Vocational Potential of the Quadriplegic. *Med Clin North America* **53**:713 (May), 1969.
3. Spangler, D. P.: Service Needs of Paraplegics and Quadriplegics. National Paraplegic Foundation, 1968.

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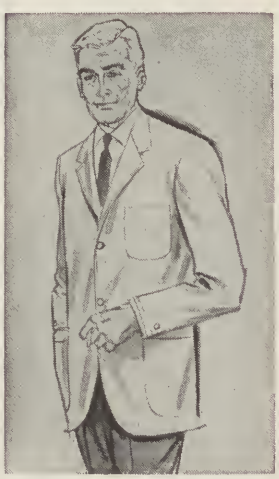
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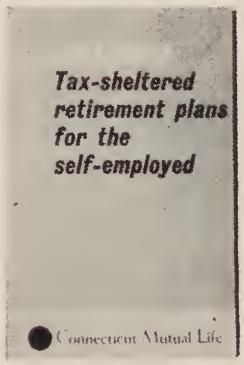


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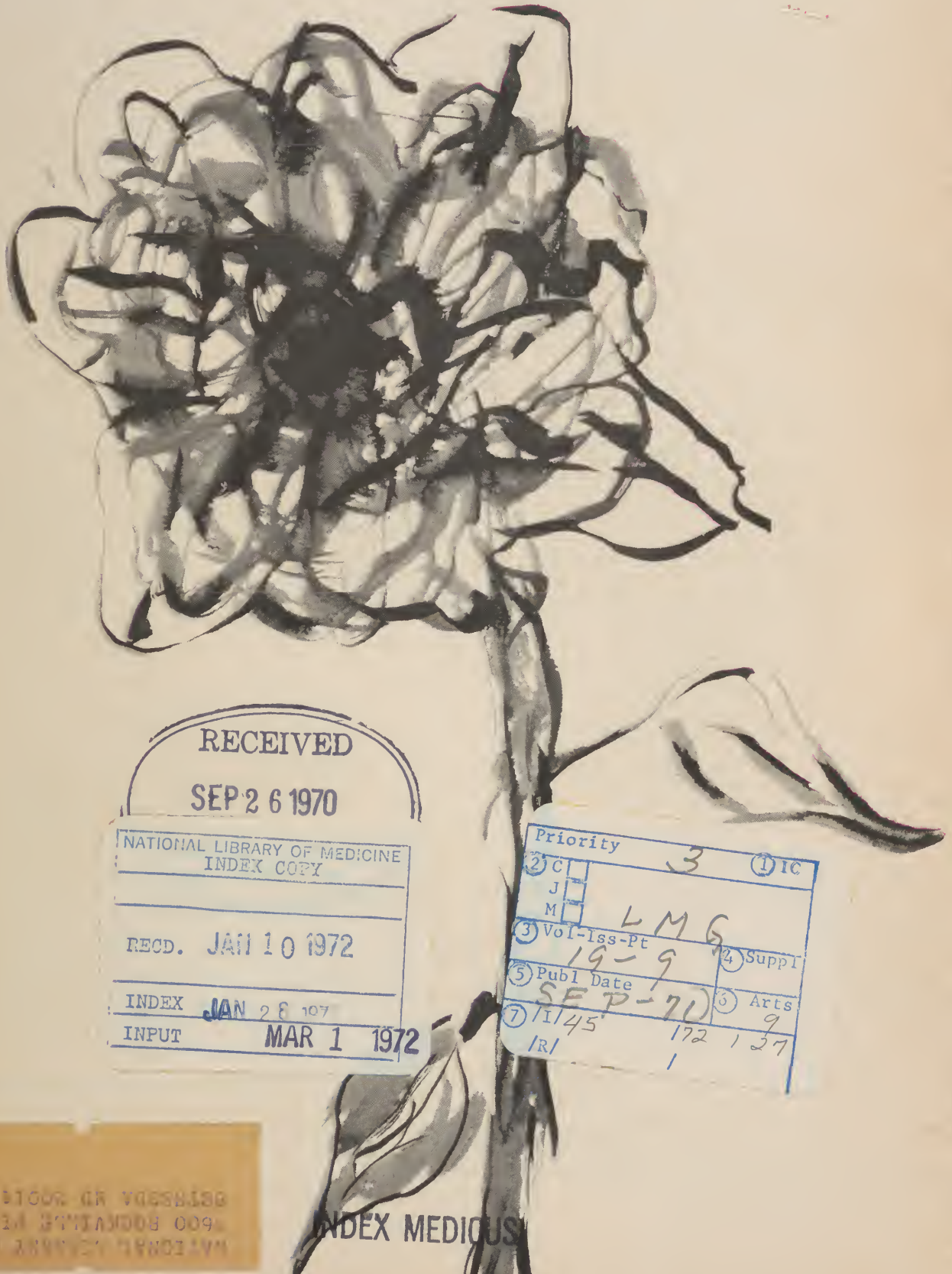
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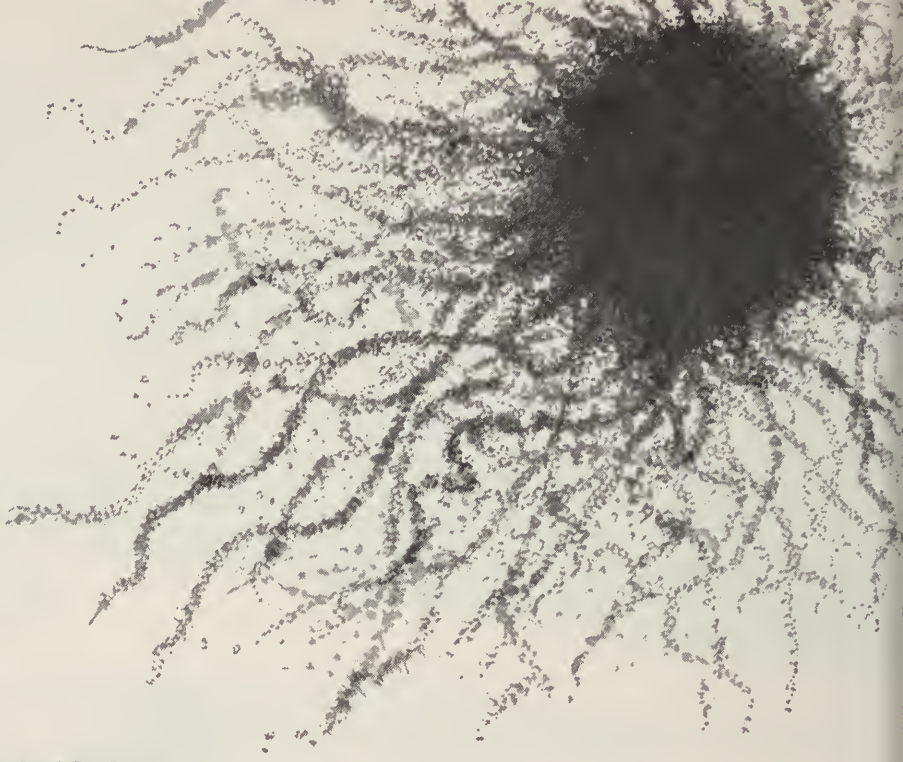
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Mental Health and the Physician: Who Worries About His? Roy W. Menninger, MD 58

"It is an interesting paradox that members of a profession committed to the reduction of disease and disability can be so curiously resistant to these same efforts when applied to themselves. When the help they need is psychological, their reluctance approaches infinity."

The Future of Medical Education, George James, MD 63

"The medical school of the future must accept the responsibility of leadership at the apex of a large pyramid of health and medical curricula for our future health workers. It must play this role within its university and for its community."

The Emerging Physician's Assistant, Hu C. Myers, MD 68

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Pulmonary Embolism—Its Cause and Prevention, William H. Moretz, MD 73

"The incidental application of a partially occluding clip in the thrombosis-prone patient during laparotomy is an important concept. This concept may ultimately outweigh in importance the present philosophy of considering surgical interruption of the inferior vena cava only after pulmonary embolism has occurred."

Maryland's New Mental Hygiene Law, Irene L. Hitchman, MD 75

"In response to a joint resolution of the General Assembly of Maryland, Governor J. Millard Tawes appointed a commission in 1966 to prepare substantive changes, as necessary, in the mental health laws of Maryland."

DEPARTMENTS:

Alcoholism—The Early Alcoholic: Kindness vs. Confrontation, Willard O. Foster, Jr. 31

Your Medical Faculty at Work, John Sargeant 78

Baltimore City Health Department—Health Services for Summer Programs 81

Library Page—Recent and Upcoming Library Meetings, New Accessions ... 87

Maryland State Department of Health and Mental Hygiene—Fact Sheet for the 1970 Fiscal Year, Implications of Recent Maryland Birth Statistics .. 99

Rehabilitation Notes—Osteoarthritis of the Lumbar Spine, Renato S. Lapidario, MD 103

Heart Page—Dietary Salt (Sodium Chloride) Intake and Arterial Hypertension: Part 2, Elijah Saunders, MD 109

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Doctors Take Note 5

Executive Director's Newsletter 9

Annual Meeting News 17

Woman's Auxiliary 19

MEDIC program for 1970-1971 21

Annual Meeting Scientific Exhibit Form 28

Book Reviews 33

Information for Authors 37

Medical News 40

The Month in Washington 43

1971 Semiannual Meeting News 107

Advertising Index 113

Classified Advertising 114


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SEPTEMBER 22, 1970
JOINT ANESTHESIA STUDY COMMITTEE/BALTIMORE CITY MEDICAL SOCIETY/BALTIMORE CITY HEALTH DEPARTMENT

Lecture and Case Report—Anesthesia for Surgery of the Eye and Its Medicolegal Implications: 7:30 PM, Osler Hall, 1211 Cathedral St., Baltimore, Md. Speaker: William E. Bageant, MD, vice-chairman, Department of Anesthesiology, Washington Hospital Center, Washington, D.C. Contact: Calbert T. Seebert, MD, University of Maryland Hospital, Department of Anesthesiology, Redwood and Greene Streets, Baltimore, Md. 21201.

SEPTEMBER 22-25, 1970
SLOVAK MEDICAL SOCIETY

1st Danube Congress of Obstetrics and Gynecology: Bratislava, Czechoslovakia. Contact: Slovak Medical Society, Congress Office Bratislava, Mickiewiczova 18 Czechoslovakia.

SEPTEMBER 23-24, 1970
MEDICAL ASSISTANTS SEMINAR

Meeting: Belvedere Hotel, Charles & Chase Sts., Baltimore, Md. Contact: Medical and Chirurgical Faculty, 1211 Cathedral St., Baltimore, Md. 21201.

SEPTEMBER 24-26, 1970
CENTRAL ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

Annual Meeting: Chicago, Illinois. Contact: David G. Decker, MD, Secretary-Treasurer, 200 First Street, S.W., Rochester, Minnesota 55091.

SEPTEMBER 29, 1970
HEART ASSOCIATION OF MARYLAND

G.P. Symposium—Hypertension: Bishop Walsh High School, Cumberland, Md. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

SEPTEMBER 30, 1970
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

1st Nationwide Private Doctors Institute: Richmond, Va. Contact: Association of American Physicians and Surgeons, 230 N. Michigan Ave., Suite 1000, Chicago, Ill. 60601.

SEPTEMBER 30-OCTOBER 1, 1970
AMERICAN MEDICAL ASSOCIATION

30th Annual Congress on Occupational Health: Los Angeles, Calif. Contact: American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

OCTOBER 3, 1970
STATE HOSPITAL FOR CRIPPLED CHILDREN

Meeting—Management of the Traumatic Paraplegic Child: State Hospital for Crippled Children, Elizabethtown, Pa. Contact: Robert Saunderson, MD, Medical Director, State Hospital for Crippled Children, Elizabethtown, Pa.

OCTOBER 4, 1970
AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Luncheon Seminar—Cryosurgical Procedures in EENT, and Annual Meeting: Dunes Hotel, Las Vegas, Nevada. For information, write: Secretary, Society for Cryosurgery, 30 N. Michigan Avenue, Chicago, Illinois 60602.

OCTOBER 4-9, 1970
AMERICAN MEDICAL SOCIETY OF VIENNA

Medical Week in Vienna: Vienna, Austria. Seminars will be included. Contact: 11 Universitaitsstrasse, M. Arthur Kline, MD, Vienna, Austria.

OCTOBER 5, 1970
MARYLAND SOCIETY OF INTERNAL MEDICINE/INTERNAL MEDICINE SECTION, BALTIMORE CITY MEDICAL SOCIETY

Meeting: 8:15 PM, Osler Hall, 1211 Cathedral St., Baltimore, Md. Speaker: Denwood N. Kelly, president, Maryland Blue Shield. Contact: Gordon Cader, MD, 611 Park Ave., Baltimore, Md.

OCTOBER 5-9, 1970
AMERICAN ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

75th Annual Session: Las Vegas, Nev. Contact: Ted Berland, 2729 W. Lunt Ave., Chicago, Ill. 60645.

OCTOBER 8-9, 1970
MID-ATLANTIC STATES SECTION, AIR POLLUTION CONTROL ASSOCIATION

Annual Conference: Harrisburg, Pa. Contact: William O. Farley, Director of Public Information, Consolidated Edison Company of New York, 4 Irving Place, New York, N.Y. 10003.

(Continued on page 13)

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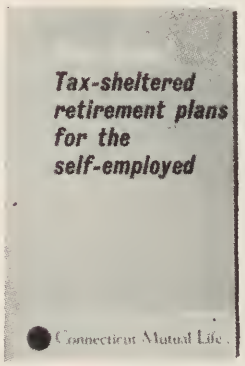


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executive director's newsletter

September, 1970

Members are reminded that the long-standing policy of the AMA permits individual members to express their opinions on matters pending before the AMA House of Delegates. The Reference Committee hearings are open to the public, as well as to interns, residents and medical students.

At the June 1970, Annual Session, a special Reference Committee was established for the purpose of hearing from minority groups, as well as interns, residents and others who wished to speak out with respect to health care matters.

BOARD EXAMINATIONS

In December 1970, the Board of Medical Examiners will initiate the FLEX examination. This is a uniform, nationwide examination for medical licensure that is machine graded and provides various options for answers.

The FLEX examination will be given as a unit, except for re-examination purposes. The basic Science portion of the examination and the Clinical Science portions will not be separated as they have been previously.

Opportunities for re-examination in certain subjects will be provided to those who have previously failed. Re-exams will be given in December 1970 and again in June 1971. The format will remain the same.

After June 1971, any unsuccessful candidate will be required to take the FLEX examination for licensure and, in addition, must make proper re-application for same.

REGULATIONS ON ADVERTISING

The Board of Medical Examiners has adopted new regulations regarding advertising, as stipulated by the revised Medical Practice Act.

An opportunity to examine these regulations, and to make comment on them is available to all interested parties for a 30-day period. Following this period, such regulations will go into effect and have the force of law.

TRIENNIAL REGISTRATION

The Board of Medical Examiners has made arrangements to see that all physicians retain the same registration number each time they are required to

TRIENNIAL REGISTRATION (cont'd)

register with the Board. This will simplify reregistration procedures and enable physicians to utilize this number in any correspondence dealing with their Maryland licensure.

1971 ANNUAL MEETING

The 173rd Annual Meeting of the Faculty will be held at the Civic Center in Baltimore, May 12, 13, 14. More space will be available for SCIENTIFIC EXHIBITS -- see page 17 of this Journal for application form or contact the Faculty office.

1971 SEMIANNUAL MEETING

The El Conquistador Hotel and Club in Las Croabas, Puerto Rico, will be the site of the 1971 Semiannual Meeting from September 15 to 19. Contact the Faculty office now for your reservations. Business sessions will be in Maryland.

MEDICAL ASSISTANTS' SEMINAR

The annual Seminar for Medical Assistants will be held on

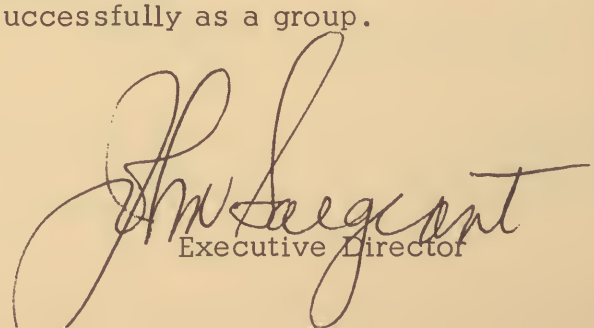
Wednesday, September 23, 1970
and
Thursday, September 24, 1970

in the Charles Room of the Belvedere Hotel, Baltimore.

Further details and preregistration form will be in the mail shortly. Watch for it!

PROFESSIONAL INCORPORATION

Professional Management Consultant Howard Baker, Waterloo, Ia., recommends 4 tests for MDs considering incorporating: (1) Group should have minimum of 2 MDs, 3 is preferable, (2) Group should have average profit per MD of at least $35,000, with no one in group lower than $30,000, (3) MDs should collectively be willing and able to contribute at least 10% of their earnings to profit-sharing plan. If all MDs cannot agree on this commitment, there is no point in proceeding with corporate plan, and (4) MDs should presently be in partnership practice together, so they know they can practice successfully as a group.



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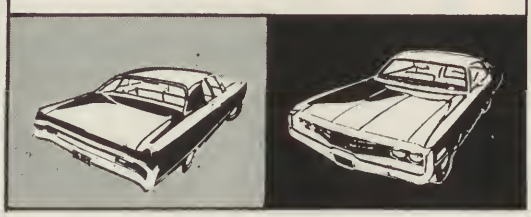
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INDICATIONS: SYNTHROID (sodium levothyroxine) INJECTION is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. It is indicated in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. When a patient does not respond to oral therapy, SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously.

PRECAUTIONS: As with other thyroid preparations, overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, insomnia and continued weight loss. These effects may become apparent in from 4 days to three weeks. Therefore, patients should be kept under close observation. Medication, in such cases, should be stopped for 2 to 6 days, then resumed at a lower level. In patients with diabetes mellitus, look for possible changes in metabolic activity which may affect insulin or other antidiabetic drug dosage requirements.

CONTRAINDICATIONS: Thyrotoxicosis, acute myocardial infarction.

SIDE EFFECTS: Side effects are secondary to increased rates of body metabolism: sweating, heart palpitations with or without pain, leg cramps, weight loss, diarrhea, vomiting and nervousness. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. In most cases, a reduction in dosage followed by a more gradual adjustment upward will indicate the patient's dosage requirements without the appearance of side effects.

DOSAGE AND ADMINISTRATION: In myxedematous stupor or coma, with no evidence of severe heart disease, 200 to 400 mcg. of SYNTHROID (sodium levothyroxine) INJECTION may be administered intravenously utilizing a solution containing 100 mcg. per ml. Detectable effects are usually observed by the sixth hour after injection and are fully appreciated during the following day. A repeat injection of 100 to 200 mcg. may be given on the second day if significant improvement has not occurred. The intravenous use of sodium levothyroxine in myxedematous coma is advantageous because it produces a predictable increase in the concentration of protein-bound iodine, eliminates the need for multiple doses until oral therapy is reinstated, circumvents the uncertainty of oral absorption, and avoids the risk of pulmonary aspiration.

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Doctors Take Note . . .

(Continued from page 6)

OCTOBER 12-16, 1970
AMERICAN COLLEGE OF SURGEONS

56th Annual Clinical Congress: Conrad Hilton Hotel, Chicago, Illinois. Eighteen accredited postgraduate courses are being offered. The Congress will also include over 60 panel discussions, numerous scientific and industrial exhibits, and many seminars. For official registration forms, contact: Mr. T. E. McGinnis, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

OCTOBER 15-16, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Postgraduate Course—Gynecology and Obstetrics: Chicago, Ill. Contact: A. Brian Little, MD, Department of Obstetrics and Gynecology, Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109.

OCTOBER 16-17, 1970
EASTERN SECTION, AMERICAN THORACIC SOCIETY

Annual Meeting: Belvedere Hotel, Baltimore, Md. For further information, contact Frank Jones at the American TB Association: 685-6484 (Balto.).

OCTOBER 17-22, 1970
AMERICAN ACADEMY OF PEDIATRICS

39th Annual Meeting: San Francisco, Calif. Contact: Department of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

OCTOBER 18-23, 1970
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

2nd Scientific Assembly: Las Vegas, Nevada. The assembly will focus on the delivery of primary care in the hospital emergency department. For information, write: Executive Secretary, 120 West Saginaw, East Lansing, Michigan 48823.

OCTOBER 18-NOVEMBER 12, 1970
AMERICAN COLLEGE OF PHYSICIANS

11th International Congress of Internal Medicine and Post Convention Tour Around the World: New Delhi, India. Cost per person: $1,935. Contact: American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

OCTOBER 25-29, 1970
AMERICAN COLLEGE OF CHEST PHYSICIANS

2nd Fall Scientific Assembly: Los Angeles, Calif. Contact: Alfred Soffer, MD, 112 E. Chestnut St., Chicago, Ill. 60611.

OCTOBER 27-30, 1970
AMERICAN ASSOCIATION OF BLOOD BANKS

23rd Annual Meeting: San Francisco, Calif. Contact: American Association of Blood Banks, Central Office, Suite 1322, 30 North Michigan Ave., Chicago, Ill. 60602.

OCTOBER 29, 1970
NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE

6th Annual Symposium: Albany, N.Y. Contact: New York State Action for Clean Air Committee, 105 East 22nd St., New York, N.Y. 10010.

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The annual Round Table Luncheon will be held at the Civic Center, and the Presidential Reception and Banquet will again be at the Blue Crest North. Members of the Faculty will again provide the Health Evaluation Tests for their fellow physicians. Many other interesting events are being scheduled.

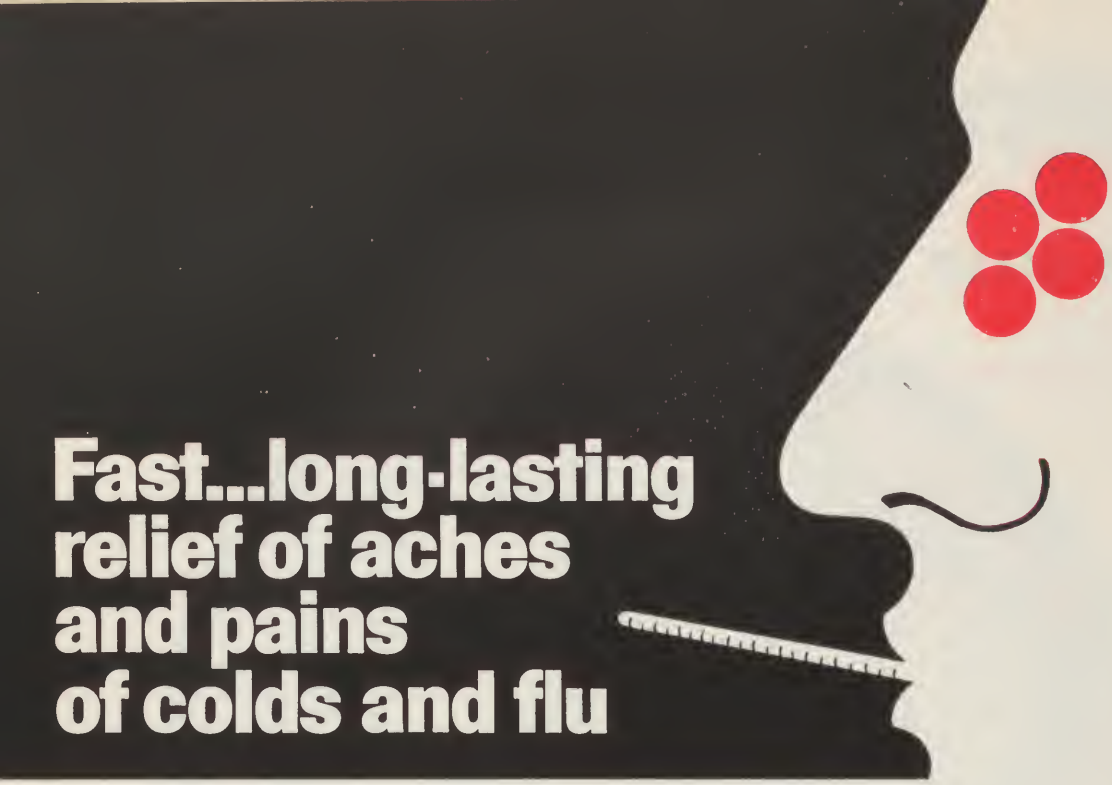
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MAY 12, 13, 14, 1971

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Annual Convention News

Mrs. DeWitt E. DeLawter
First Vice-President

Mrs. H. Leonard Warres
Representative

Mrs. Albert F. Cooper
Member-at-large

The 47th annual convention of the Woman's Auxiliary to the American Medical Association was held June 21-25, 1970 at the Drake Hotel, Chicago.

Mrs. R. C. L. Robertson was elected president of the AMA auxiliary and implemented the phrase, "Service in the 70's" as the theme of her inaugural address. Mrs. Robertson said that we should investigate and become involved. "Each of us can do something worthwhile if we but will it."

The director of the women's activities for the National Association of Manufacturers, Mrs. Louise Bushnell, was the keynote speaker at the opening session. She currently serves as liaison officer between the NAM and volunteer groups.

Mrs. Bushnell challenged the members to find the answers to the world's greatest problems by "cleaning out the cerebral cobwebs, first from ourselves and then from others." In explaining, she commented that any well-trained person with experience and ability should be hired to work in any hospital, school or business. "Snob appeal is a cobweb," she said. "We should not show prejudice of any kind. Instead, we should strive to make freedom work."

Mrs. John Chenault, outgoing president of the AMA auxiliary, reported that the work of all national committees has been increased. Many states have used the package programs. These have been updated and one on smoking has been added. According to Mrs. Chenault, the American Medical Association's Emergency Relief Fund has received over $4,000,000 since the woman's auxiliary took over the project in 1951. She also noted that a record breaking $498,950.69 was given to AMAERF this past year. This is a $70,000 increase over the preceding year.

Awards were presented to the states for their contributions. Maryland received four awards. The state auxiliary received one for being the state with the highest percent of increase over the past year. Baltimore County's auxiliary received another for donating the largest per capita contribution. Both Montgomery County's and Baltimore city's auxiliaries received awards for netting the largest contributions in their respective membership categories. The top contributor award went to California for its gift of $72,514.

A resolution was passed on health care of the poor. This resolution supports the one passed by the AMA House of Delegates at the 1969 convention. It recognizes the basic right of every citizen to have available to him adequate health care and recommends that the Program Development Committee implement this program to include care for the Indian, the migrant, and the ghetto resident.

A fashion show depicting the role of "Woman thru the Ages" was sponsored by the Community Homemakers Health Aid Service Inc., Kenosha, Wisconsin. The 32 models, who supplied and paid for the costumes which they wore, were the wives of physicians, dentists, pharmacists, and lawyers is Kenosha.

Mrs. H. Leonard Warres was named Eastern Regional Chairman of International Health.

An idea-exchange session was also conducted during the convention. Members from the various states reported what their respective states had done in order to raise money for worthwhile projects.

Arizona netted $2,200 from a "Silent Auction" for AMAERF. It also sponsored a short internship in anesthesia for a Bolivian nurse through its International Health Committee.

Hawaii collected $3,000 for AMAERF by conducting a dinner-auction.

Virginia collected new and used shoes and distributed them to needy children.

Oregon reported visits by the chairman of International Health and her husband to remote Mexican clinics, and the distribution there of some of their collected drugs.

Washington State collected 14½ tons of supplies valued at $222,825 for International Health.

New Jersey raised $1,200 for the drug abuse program from a golf tournament.

AMAERF Student Loan Guarantee Program

This year the STUDENT LOAN GUARANTEE PROGRAM has been reactivated to encourage career decisions and to help ease the financial difficulties of medical students, residents, and interns.

Each dollar contributed to this fund puts another $12.50 to work in loans made by a commercial bank. As the Loan Guarantee Fund increases from contributions and appreciation, more money becomes available for guaranteeing future loans. As loans are repaid, money in the fund becomes available once again to guarantee still more loans.

Who Is Eligible?

1. Medical students who have completed their first semester or quarter
2. Interns or residents in good standing who are United States citizens, provided they are enrolled in full-time training at a hospital approved by the Council on Medical Education of the American Medical Association

(A list of approved medical schools appears annually in the Education Number of the *Journal of The American Medical Association*. A list of hospitals with approved Graduate Training Programs is available from the American Medical Association, 535 N. Dearborn, Chicago, Illinois.)

What Are the Mechanics of This Program?

1. The medical student will find application blanks and pertinent details available through the dean's office of the medical school.
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3. Following completion, the applications are returned to the dean or hospital administrator for certification, and then forwarded to the designated bank.

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Should the individual enter the armed forces and lose his life, or should he die from other causes, the loan is automatically cancelled. Neither his family nor his heirs are held liable for repayment.



Mrs. Raymond Yow, president of the Woman's Auxiliary to the Medical and Chirurgical Faculty, displays one of three AMAERF picture awards presented to her during the national auxiliary's recent annual convention. The state auxiliary received recognition for having the largest percent of increase over the past year. The Baltimore County auxiliary donated the largest per capita contribution, and the Baltimore city and Montgomery County auxiliaries received awards for the largest per capita contributions in their respective membership categories.



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WEDNESDAY EVENING SERIES — 8:00 PM

The management of a variety of medical problems will be discussed by faculty members from The Johns Hopkins University School of Medicine. This series will be presented each month from the Greater Baltimore Medical Center on Wednesday evenings and then replayed as part of the Friday lecture series.

September 30, 1970

PRO'S AND CON'S OF PROPHYLACTIC ANTIBIOTICS

Jack M. Zimmerman, MD
Associate Professor of Surgery
Johns Hopkins School of Medicine

Charles O'Donovan, III, MD
Instructor in Medicine
Johns Hopkins School of Medicine

November 4, 1970

COMPLICATIONS OF RHEUMATOID DISEASE

Lawrence E. Shulman, MD
Associate Professor of Medicine
Johns Hopkins School of Medicine

Lee H. Riley, Jr., MD
Associate Professor of Orthopedic Surgery
Johns Hopkins School of Medicine

December 2, 1971

MANAGEMENT OF ULCERS

David B. Skinner, MD
Assistant Professor of Surgery
Johns Hopkins School of Medicine

Thomas R. Hendrix, MD
Professor of Medicine
Johns Hopkins School of Medicine

February 3, 1971

MANAGEMENT OF U.T.I.

Patricia Charache, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

March 3, 1971

ILEOSTOMY AND COLOSTOMY MANAGEMENT

Marvin M. Schuster, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

March 31, 1971

F.U.O. — MEDICAL OR SURGICAL?

Philip A. Tumulty, MD
Professor of Medicine
Johns Hopkins School of Medicine

May 5, 1971

REPARATIVE CARDIAC SURGERY

Vincent L. Gott, MD
Professor of Surgery
Johns Hopkins School of Medicine

J. O'Neal Humphries, MD
Associate Professor of Medicine
Johns Hopkins School of Medicine

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- **FIRST FRIDAY** — The management of a variety of medical problems will be discussed by faculty members from The Johns Hopkins University School of Medicine. This series will be presented live from the Greater Baltimore Medical Center on Wednesday evenings and then replayed as part of the Friday lecture series.

- **SECOND FRIDAY** — In conjunction with the Department of Family Medicine at the University of Maryland School of Medicine, a series of topics have been scheduled for presentation from St. Agnes Hospital. The faculty will be composed of members from the University of Maryland School of Medicine.

September 25, 1970
MANAGEMENT OF CONVULSIONS
Guy Mead McKhann, MD
Director, Department of Neurology
Johns Hopkins School of Medicine

October 2, 1970
PRO'S AND CON'S OF PROPHYLACTIC ANTIBIOTICS
Jack M. Zimmerman, MD
Associate Professor of Surgery
Johns Hopkins School of Medicine
Charles O'Donovan, III, MD
Instructor in Medicine
Johns Hopkins School of Medicine

October 9, 1970
THE DRUG PROBLEM
Russell R. Monroe, MD
Professor of Psychiatry and
Director of Graduate Training
University of Maryland School of Medicine

October 16, 1970
ALCOHOLISM
Esteban Mezey, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

Ostober 23, 1970
SUBDURAL EFFUSIONS
Robert M. N. Crosby, MD
Associate Professor of Neurological
Surgery and Instructor in Pediatrics
University of Maryland School of Medicine

October 30, 1970
WHO CARES FOR THE ALCOHOLIC
(A live interview with an alcoholic)
Maxwell N. Weisman, MD
Director, Division of Alcoholism Control
State Department of Health and Mental Hygiene

November 6, 1970
COMPLICATIONS OF RHEUMATOID DISEASE
Lawrence E. Shulman, MD
Associate Professor of Medicine
Johns Hopkins School of Medicine
Lee H. Riley, Jr., MD
Associate Professor of Orthopedic Surgery
Johns Hopkins School of Medicine

November 13, 1970
BACTERIAL ENTERITIS
Herbert L. Dupont, MD
Instructor, Infectious Disease Division
University of Maryland School of Medicine

November 20, 1970
COMA — THE PHYSICIAN AND THE COMATOSE PATIENT IN THE EMERGENCY ROOM
Thomas J. Preziosi, MD
Assistant Professor of Neurology
Johns Hopkins School of Medicine

November 27, 1970
RADIOGRAPHIC AND RADIOISOTOPIC PROCEDURES IN THE EVALUATION OF NEUROLOGICAL PATIENTS
Giovanni Di Chiro, MD
Section on Neuroradiology
National Institutes of Health

December 4, 1970
MANAGEMENT OF ULCERS
David B. Skinner, MD
Assistant Professor of Surgery
Johns Hopkins School of Medicine
Thomas R. Hendrix, MD
Professor of Medicine
Johns Hopkins School of Medicine

December 11, 1970
TEMPORAL ARTERITIS AND CATARACTS
Richard D. Richards, MD
Professor and Head
Department of Ophthalmology
University of Maryland School of Medicine

December 18, 1970
DRUG ABUSE — THE BARBITURATES
Joseph R. Bianchine, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

January 8, 1971
ORAL MANIFESTATIONS OF SYSTEMIC DISEASE
John F. Hasler, DDS, MSD
Assistant Professor of Oral Diagnosis and Radiology
University of Maryland School of Dentistry

January 15, 1971
SICKLE CELL CRISES
Philip D. Zieve, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

January 22, 1971
THE HYPERACTIVE CHILD
Dennis Whitehouse, MD, MRCP
Assistant Professor of Pediatrics
Johns Hopkins School of Medicine

THESE PROGRAMS WILL BE REPLAYED MONDAYS AT 12:3

- **THIRD FRIDAY** — Illustrative case material from the Emergency Room at the Baltimore City Hospitals will be used to initiate a discussion of various problems commonly seen and requiring immediate management. Participating in the discussion will be directors of emergency departments throughout the state.

- **FOURTH FRIDAY** — The general theme of this series of talks will be neurological disease. Various aspects will be explored by a distinguished faculty. The host for this series is the medical staff of the Frederick Memorial Hospital.

January 29, 1971
ALTERATION OF THE HORMONAL MILIEU IN THE MANAGEMENT OF ADVANCED BREAST CANCER
John H. Mather, MD
Department of Surgery
University of Maryland School of Medicine

February 5, 1971
MANAGEMENT OF U.T.I.
Patricia Charache, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

February 12, 1971
FAMILY INTERACTION IN ILLNESS
Frank T. Rafferty, MD
Professor of Psychiatry and Director
Division of Child Psychiatry
University of Maryland School of Medicine

February 19, 1971
ACUTE MUSCULOSKELETAL TRAUMA
Thomas A. Otter, MD
Assistant Resident in Orthopedic Surgery
Johns Hopkins School of Medicine

February 26, 1971
L-DOPA AND PARKINSONISM
William O'Malley, MD
Director of Research at Parke-Davis
on L-Dopa
Ann Arbor, Michigan

March 5, 1971
ILEOSTOMY AND COLOSTOMY MANAGEMENT
Marvin M. Schuster, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

March 12, 1971
PRE-HOSPITAL MANAGEMENT OF MYOCARDIAL INFARCTION
Leonard Scherlis, MD
Professor of Medicine and Head,
Division of Cardiology
University of Maryland School of Medicine

March 19, 1971
ALLERGIES AND ANAPHYLACTIC REACTIONS
Philip S. Norman, MD
Associate Professor of Medicine
Johns Hopkins School of Medicine

March 26, 1971
NEWER DEVELOPMENTS IN EPILEPSY
James Kiffin Penry, MD
Head, Section on Epilepsy
National Institute of Neurological
Diseases and Stroke

April 2, 1971
F.U.O. — MEDICAL OR SURGICAL?
Philip A. Tumulty, MD
Professor of Medicine
Johns Hopkins School of Medicine

April 9, 1971
SOME ASPECTS OF SHOCK TRAUMA
R. Adams Cowley, MD
Professor and Head
Division of Thoracic Surgery
Director
Center for the Study of Trauma
University of Maryland School of Medicine

April 16, 1971
G.I. BLEEDING—EMERGENCY ASPECTS
Marvin M. Schuster, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

April 23, 1971
MIGRAINE AND RELATED HEADACHES
William G. Speed, III, MD
Assistant Professor of Medicine
Johns Hopkins School of Medicine

April 30, 1971
UNEXPLAINED FEVER IN INFANTS
Fred J. Heldrich, Jr., MD
Chairman, Department of Pediatrics
St. Agnes Hospital
Assistant Professor of Pediatrics
Johns Hopkins School of Medicine

May 7, 1971
REPARATIVE CARDIAC SURGERY
Vincent L. Gott, MD
Professor of Surgery
Johns Hopkins School of Medicine
J. O'Neal Humphries, MD
Associate Professor of Medicine
Johns Hopkins School of Medicine

May 14, 1971
OCCUPATIONAL DERMATOSIS
Harry M. Robinson, MD
Professor and Head
Department of Dermatology
University of Maryland School of Medicine

May 21, 1971
OBSTRUCTIVE PULMONARY DISEASE
Douglas G. Carroll, Jr., MD
Associate Professor of Medicine
Johns Hopkins School of Medicine
Stephen M. Nagy, Jr., MD
Fellow in Medicine
Johns Hopkins School of Medicine

May 28, 1971
ENCEPHALOPATHY — LEAD
Julian J. Chisolm, Jr., MD
Associate Professor of Pediatrics
Johns Hopkins School of Medicine

ESDAYS AT 7:30 AM, 9:00 AM and 2:00 PM

CONTINUING PROGRAMS

(Heard at participating hospitals only)

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University of Maryland Hospital

WEDNESDAYS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

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North Charles General, Baltimore
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Physicians Memorial, La Plata
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
University of Maryland, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

Other locations:

Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
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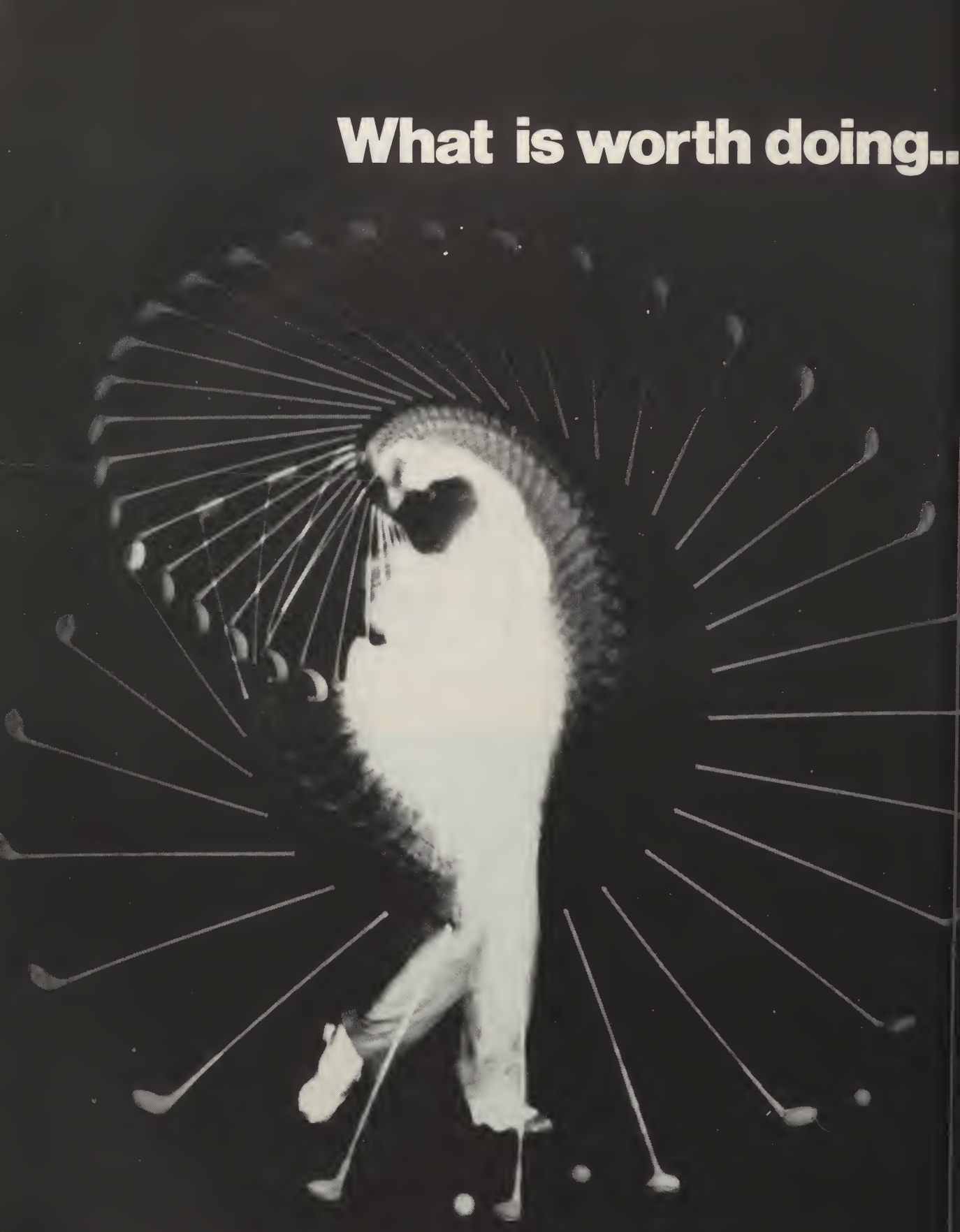
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SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 12, 13, 14, 1971
Civic Center, Baltimore

More space is available than in former years. However, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

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5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

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7. Name of institution cooperating in the exhibit: _____

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8. Address of exhibitor: _____

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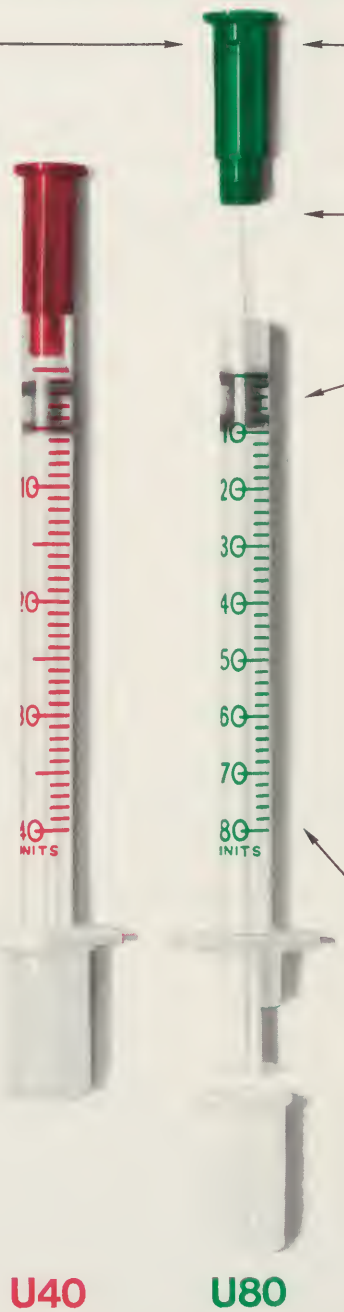
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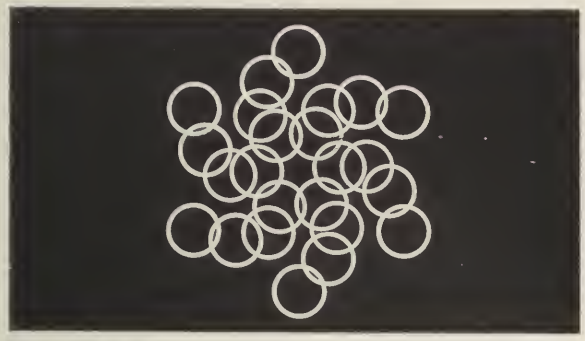
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

The Early Alcoholic: Kindness vs. Confrontation

WILLARD O. FOSTER, JR.
Industrial Program Advisor
Division of Alcoholism Control
Maryland Department of Health and Mental Hygiene

To survive on any job, an employee with alcoholism must keep his illness and its effects a deep, dark secret. He may be unaware that he is suffering from a treatable condition, but he is still aware that his drinking habits make him vulnerable to discipline or discharge, and they must be concealed at all costs. When, especially in the later stages of his disease, his behavior unwittingly reveals the extent of his drinking, he is driven to even greater lengths, either to conceal this behavior, or to offer alibis for it.

During the early stages of alcoholism, the business of remaining invisible is not too difficult for the average employed drinker. He generally has a ready and apt alibi for the relapses that do occur. He covers his initial high rate of absenteeism with sick leave certificates obtained for a variety of obscure ailments from an equal variety of unsuspecting or well-meaning physicians. His initial hangover difficulties at work he comfortably and convincingly ascribes to off-the-job problems, which include everything from his mother-in-law to an ailing rosebush in the front yard. The result is that he is seldom directly confronted with the possibility that he may be in trouble with alcohol.

As his disease progresses, his behavior becomes more difficult to conceal and, of necessity, his alibis become more grotesque. By now he has become highly skilled in arousing and depending upon a sympathetic attitude on the part of his fellow employees to protect him from the more serious consequences of his actions.

Here indeed we have an unhappy situation. As with any other illness, alcoholism is most amenable to treatment in its early stages. And like many other illnesses, alcoholism becomes more resistant to treatment as time goes by. Thus, after a period that may be as long as ten or more years, his disease becomes so firmly entrenched that treatment leading to his sobriety is more difficult and, unfortunately, in too many cases, impossible.

Many of the better-known corporations in the United States have adopted firm and expressed policies with respect to the employee with alcoholism. These policies have come about through the realization that rehabilitation of the alcoholic employee, especially in the earlier stages of his illness, is far less costly and more humane than ignoring him and allowing the inevitable consequences of his actions to result in his eventual death.

In some companies, however, the publication of such a policy, even when accompanied by detailed procedures as to the means by which the policy will be carried out, has not always demonstrated the degree of success that experience in other companies might indicate.

Dr. Harrison M. Trice of the New York School of Industry and Labor Relations at Cornell University defines this problem as a "policy-practice gap" and has given it research attention. Certain findings from his studies create interesting speculation about interpersonal relationships and alcohol abuse. These findings are applicable even outside the work world and serve to explain, at least in part, the ambivalence toward the sick alcoholic demonstrated by community care-givers and care-giving agencies.

Initially, it must be recognized that, common to

our cultural and community attitudes toward drinking and intoxication, there is a measure of tolerance as long as drinking behavior does not become too socially objectionable. Similarly, this same feeling is expressed at any given level in a company organization, when work habits first show the effect of alcohol abuse.

Naturally, the alcoholic is aware of and shares in this attitude. Skillfully, he uses it to his advantage in the earlier stages of his illness when his occasional lapses in behavior are noticeable on the job. Thus, his fellow employees, including immediate supervisors, tend to overlook his behavior with a degree of sufferance born of this community point of view. At the supervisory level, this tolerance is even accompanied by overt feelings of protective paternalism. Similar feeling can be demonstrated in authority figures surrounding the alcoholic in the community.

Much of the training of industrial supervisory personnel in the identification of the signs of early alcoholism fails to take these benevolent attitudes into account. Even though the training enables the supervisor to recognize those early signs pointing to drinking problems, he is seldom truly motivated to take the necessary corrective action.

We now have a situation where, not only is the economic and humanitarian value of the company policy negated, but during the very period when most can be done for the alcoholic employee, nothing constructive is done because of misplaced and incorrect attitudes. By the time the behavior of the alcoholic can no longer be condoned, when his alibis become totally unbelievable, and genuine concern is being expressed by his fellow employees and supervisors, the possibility of offering the alcoholic any true help through a company program is doubtful indeed. Again, the same situation applies in the community outside his work world as the alcoholic comes inevitably to the attention of law enforcement, health, and social welfare agencies.

Resolution of the problem for an industrial organization is not always easy. Frequently, we overlook the fact that the alcoholic employee is a true threat to his fellow employees and supervisor, even in the early stages of his disease. The very signs used for early identification of his drinking problem demonstrate this. Regular and unexcused absenteeism, lack of efficiency due to hangovers, a proneness to accidents, together with various unwholesome personality changes, interfere with his own job performance as well as the performance of his fellow employees. He becomes a distinct detriment to the proficiency of the entire working group of which he is a member.

Supervisory personnel can and should be trained to recognize these facts as being threatening to their own job situations and ratings as supervisors. In those industries where the training of supervisors has taken this slant, there has been a marked and rewarding increase in the numbers of employees referred at the early stages of their illness, and a correspondingly higher rate of successful rehabilitation—in some programs as high as 70%.

The parallel in the community should be obvious. To ignore the early signs of alcoholism intentionally as a well-meaning, tolerant gesture is as damaging to the alcoholic as if the same type of response were to be made to the early signs of cancer. Both are terminal illnesses if not arrested by one means or another. To the community, the alcoholic becomes a clear and constant threat as his illness progresses. The valid statistics of traffic fatalities, suicides, homicides, child abuse, divorce, and other community problems stemming from alcohol abuse point this out ever so clearly.

As the supervisor is trained to recognize his employee with alcoholism at the earliest possible time, so must the care-giver be made aware of the threat to the community of his alcoholic patient or client, if his illness is allowed to progress unchecked. Misguided and well-meaning tolerance and ambivalence by care-givers represent a distinct failure in the delivery of their services, and is indefensible morally and legally. As the community care-giver learns and accepts this lesson from industry, the individual and community tragedy that is alcoholism can be significantly relieved.

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Book Reviews

DIFFERENTIAL DIAGNOSIS: THE INTERPRETATION OF CLINICAL EVIDENCE, second edition, A. McGehee Harvey, MD, and James Bordley, III, MD; The W. B. Saunders Company, Philadelphia, Pennsylvania, 1970.

The scope of the second edition of this publication has been expanded, and each of the chapters has been largely rewritten. New chapters have been included dealing with hypertension, anemia, diarrhea and malabsorption, and special neurological problems.

Credit is given in the preface to the various people at The Johns Hopkins Medical Institutions for their assistance and permission to use material.

Essentially, this is a case-by-case analysis of patients who have suffered from the various diseases discussed. Its material is taken from CPCs at Johns Hopkins Hospital and other institutions. It summarizes and uses only the essential information from the clinical histories, physical examinations, and progress notes. In so doing, it has made the material somewhat difficult to assimilate. It is, nonetheless, worthwhile reading, especially for its instructional material.

DISABILITY IN ANTIQUITY, Fareed Haj; Philosophical Library, Inc., New York, New York, 1970.

This book studies the major medical and social causes of disability in the Near East during the Middle Ages. While it is primarily of interest to students of ancient and medieval history, those involved in public health will also be interested in this subject.

CANADIAN MEDICAL DIRECTORY, Secombe House, Toronto, Ontario, Canada, 1970.

The 16th edition of this publication is now available which provides a comprehensive listing of all physicians in Canada, as well as other relevant and pertinent medical data not available from any other source.

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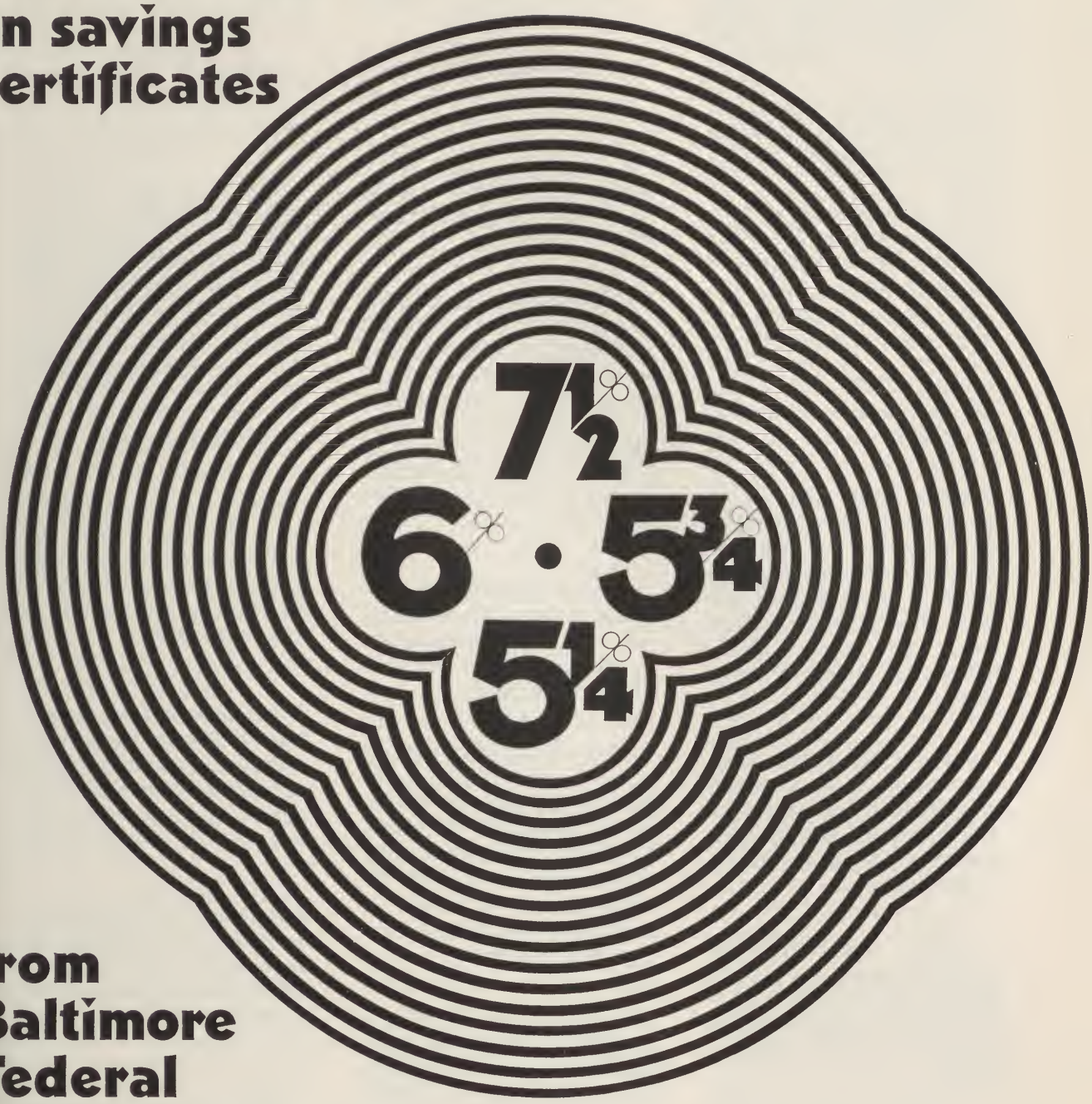
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MEDICAL NEWS

Edward F. Lewison, MD, Chief of the Breast Cancer Clinic of The Johns Hopkins Hospital, is the only United States participant among ten breast cancer experts at the World Health Organization Committee headquarters in Geneva, Switzerland.

The committee, and the studies it sponsors, is the first WHO program dealing with clinical control of cancer.

Dr. Lewison explained that breast cancer is the most common form of the disease. An estimated 70,000 U.S. women will develop breast cancer during 1970.

* * *

Robert Traub, MD, of the department of microbiology at the University of Maryland School of Medicine, recently attended a Naval Medical Research Unit conference in Cairo, Egypt, where he led a discussion on the ecology of scrub typhus.

* * *

Robert W. Gibson, MD, Medical Director of the Sheppard Pratt Hospital, has received the 1970 Edward A. Strecker, MD, Award as "Young Psychiatrist of the Year".

* * *

Samuel P. Asper, MD, Professor of Medicine, has been appointed Vice-President for Medical Affairs, a newly-created position at The Johns Hopkins Hospital.

Dr. Asper will work with heads of the patient care departments to achieve maximum coordination and effectiveness of patient programs within the hospital.

* * *

Governor Marvin Mandel recently announced the addition of 20,000 needy persons to Maryland's Medicaid roles. This move was made possible through efficiencies implemented under the Governor's executive reorganization program.

* * *

Haig H. Kazazian, Jr., MD, Assistant Professor of Pediatrics at The Johns Hopkins Hospital, was one of eight young American physicians recently awarded traveling fellowships by the Royal Society of Medicine Foundation, Inc. The $2,500 award is for a three-month study in Great Britain.

* * *

Francine Camitta, MD, and **Young E. Chun, MD,** have been appointed associates in medicine at the University of Maryland School of Medicine.

* * *

Chris Papadopoulos, MD, of Baltimore, has been elected president of the Baltimore Metropolitan Division of the Health Association of Maryland. Dr. Papadopoulos is the chief of cardiology and the director of the coronary unit at South Baltimore General Hospital.

* * *

A series of experiments dealing with the **cultivation of the leprosy bacillus** are being conducted by **Claude V. Reich, PhD,** at The Johns Hopkins University.

The project is being financed with a grant from the John A. Hartford Foundation to the Leonard Wood Memorial for the Eradication of Leprosy.

Dr. Reich is the Laboratory Director at the Leonard Wood Memorial in New York.

* * *

John E. Hoopes, MD, has been named Professor and Director of Plastic Surgery, a division of the department of surgery at The Johns Hopkins University School of Medicine.

Besides teaching interns, residents, and medical students at Johns Hopkins, Dr. Hoopes will also teach at Baltimore's City and Children's hospitals.

* * *

Mary P. Sanders Price, Director of The Johns Hopkins Hospital School of Nursing, and the Hospital's Nursing Services, retired recently. She had been director since 1955.

* * *

The Johns Hopkins Hospital Board of Trustees has approved conversion of the hospital's nursing education from a three-year diploma school to a cooperative program with academic institutions.

Under this plan, which was recommended to the trustees by the school of nursing advisory board, the school will accept its last class this fall, and close following the class's graduation in 1973.

* * *

Morris L. Scherr has become the Executive Assistant in the office of the Medical Director at the Sheppard Pratt Hospital. Previously, Mr. Scherr had been the executive director for the Metropolitan Baltimore Mental Health Association.

* * *

David G. Simpson, MD, was recently elected **President of the**

Maryland Thoracic Society, the medical arm of the Maryland Tuberculosis and Respiratory Disease Association.

Allan D. Moodie, MB, DPH, was elected Vice-President and **Mary C. Riley, MD,** was elected Secretary-Treasurer.

* * *

John T. Chissell, MD, of Baltimore, was recently installed as President of the Maryland Academy of General Practice, by Edward J. Kowalski, MD, President of the American Academy of General Practice.

* * *

The Saint Francis Hospital in Beech Grove, Indiana, is attempting to solve the paramedical manpower shortage by a formal training program for obstetrical technicians. The clinical study involves nursing arts, surgery and obstetrics, as well as classes in microbiology, anatomy, physiology, nutrition and interpersonal relations.

Information about this program can be obtained by writing the Staff Education Department, Saint Francis Hospital, 101 North 17th Ave., Beech Grove, Indiana.

* * *

The Department of Specialty Society Services was recently established by the American Medical Association to strengthen services to related medical organizations. Its new director will be Theodore R. Chilcoat, formerly an employee of the Faculty.

* * *

An amendment to Medicare regulations will make it possible for more physical therapists to qualify as practitioners under the Medicare program.

This amendment, according to Robert Ball, Commissioner of Social Security, will specify the alternatives to the present education and experience requirements for physical therapists.

* * *

"With extreme reluctance", Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, announced the **retirement of Edward Davens, MD,** Acting Commissioner of the State Department of Health since February 1970.

Dr. Davens, who will now serve as Coordinator of the Regional Medical Program, has been succeeded by **Jean Rose Stiffler, MD.**

* * *

"Automotive Restraint Devices for the Pediatric Patient," an article appearing in a recent issue of *Pediatrics,* the official journal of the American Academy of Pediatrics, has called on physicians to recognize the importance of restraining devices for children.

If more children had been required to use properly designed devices (bassinets, safety harnesses, lap belts, etc.), many of the 5,900 children under 15 years of age who died in motor vehicle accidents in 1969 would have lived, according to the Academy.

* * *

Howard Garber, MD, Chief of the Division of Communicable Diseases, warns Marylanders to guard against dog ticks. Ticks can carry and transmit the organism which causes Rocky Mountain spotted fever.

Last year there were 48 confirmed cases of the disease in Maryland, resulting in three deaths.

* * *

Thomas D. McKewen will head the Directorate for Environmental Health Services, recently created by Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene. Previously, Mr. McKewen had served as Assistant Commissioner for Environmental Health Services of the State Department of Health.

* * *

Margaret Wiedorn Bridwell, MD, of Washington, D.C., recently became the first gynecologist to serve full-time with the University of Maryland Health Service. Dr. Bridwell, who is also a member of the board of Friendship House in the District of Columbia, is the second woman on the medical staff.

* * *

Gerald R. Clark, MD, has been selected as "Physician of the Year," by the American Medical Association and the President's Committee on the Employment of the Handicapped. Dr. Clark, a psychiatrist, is presently serving as president of Elwyn Institute, Elwyn, Pennsylvania.

Under Dr. Clark's leadership, Elwyn has changed from a custodial institution into one which focuses on education.

* * *

Paul M. Leand, MD, of Baltimore, has left his position as Assistant Professor of Surgery and member of the surgical staff of the Johns Hopkins Hospital to enter the private practice of surgery.

Dr. Leand is board certified in general surgery and thoracic surgery. His office is located at 222 West Cold Spring Lane in Baltimore.

* * *

Metropolitan Baltimore state hospitals graduated the first class of Psychiatric Aides in a jointly sponsored union and state upgrading program. The 64 graduates (57 women and 7 men) are among the first in the country to be graduated from the Hospital Career Development Program, developed by the Ameri-

can Federation of State, County and Municipal Employees (AFSCME) AFL-CIO, under a $1.2 million grant from the U.S. Departments of Labor and Health, Education, and Welfare.

Courses were held at Rosewood, Spring Grove, and Crownsville state hospitals.

* * *

The Department of Health and Mental Hygiene has announced the creation of a new division, a **Vendor Relations Team.** The new unit will be charged with liaison responsibilities between the Department and the providers of services for the Medical Assistants Program.

* * *

Robert M. Ball, Commissioner of Social Security, recently stated that new regulations would be established to make certain that Medicare and Medicaid do not recognize inflated values of profit-making health facilities in paying costs of medical care for the aged.

"This is part of the continuing effort to eliminate all possible fiscal loopholes—potential as well as existing—in the operation of these problems," according to Commissioner Ball.

* * *

Stanley F. Yolles, MD, Director of the National Institute of Mental Health, Health Services and Mental Health Administration, Chevy Chase, announced the creation of a new national training program in suicidology.

Conducted by the training staff of the Institute's National Center for Mental Health Services, Training and Research, in collaboration with the NIMH Center for Studies of Suicide Prevention, the program will take place on the grounds of Saint Elizabeths Hospital in the District of Columbia, and in a variety of local field assignments.

Further information and applications may be obtained by writing to Henry Lederer, MD, 2700 Nichols Avenue, S.E. Washington, D.C. 20032.

* * *

The American Medical Association reports that the war continues between the American Chiropractic Association and members of the scientific community. Recently, the *Senior Citizen's News* published an article entitled "Why Chiropractic Cult Cannot Provide Quality Health Care," and concluded that chiropractic treatment is at best worthless and at worst mortally dangerous.

The AMA states that medicine opposes chiropractic for the same reason it opposes other forms of health quackery and it will try to prohibit poorly trained individuals from performing functions for which they are totally unqualified.

* * *

The Johns Hopkins Medical Institutions and The Good Samaritan Hospital jointly announced that they are beginning a new and cooperative program in rehabilitation medicine.

Arthur K. Siebens, MD, professor and chairman of the department of rehabilitation medicine at the University of Wisconsin Medical Center, will join the institutions to head the program's development.

* * *

The National Association of Residents and Interns, headquartered in New York, released details regarding a new loan program for its members.

A qualifying member, anywhere in the United States, may borrow up to $3,000 on an extended repayment basis—as long as five years. These funds may be used for any purpose the young physician sees fit, and no collateral is required. More information is available through NARI Headquarters, 292 Madison Ave., New York, N.Y. 10017.

* * *

"It's an unpredictable drug, used by unpredictable people, which brings about unpredictable reactions." Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, recently issued the above statement to refute the claims of Claude Brown and his brother, Henry, who advocated legalizing all drugs at a meeting sponsored by the Drug Abuse Center of the Henry T. Phipps Psychiatric Clinic of The Johns Hopkins Hospital.

Claude Brown is the author of *Manchild in the Promised Land.*

* * *

Howard B. Silverman has been appointed to the post of Regulations Coordinator of the Maryland State Department of Health and Mental Hygiene. Mr. Silverman served as assistant dean of the graduate school of Morgan State College.

* * *

According to preliminary statistics compiled by the Maryland Department of Health and Mental Hygiene, births to Maryland mothers during 1969 totaled approximately 69,000, some 600 more than those recorded in 1968. While this is the first increase of births in five years, it represents a decrease of 12.7% from the high of 79,003 births recorded in 1964.

* * *

The New York State Action for Clean Air Committee has requested New York State's electric utility companies to reduce or eliminate advertising designed to promote either new uses of electricity or conversion to electricity. Their aim is to decrease fuel usage and the resulting air pollution.

* * *



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- Hyperkalemia may occur, especially in severely ill patients with relatively small urine outputs or in patients receiving supplemental potassium. However, with Aldactone, because of its mechanism of action, hyperkalemia[3] should be less likely than with triamterene or other agents which act independently of aldosterone.
- Gradual onset of action avoids the danger[4] of sudden electrolyte and fluid depletion.
- May be effective as the sole diuretic or may be combined with a thiazide, furosemide[5] or ethacrynic acid[6].

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone, particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops.

Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 per cent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For *essential hypertension in adults* the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For *edema, ascites or effusions in adults* initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For *children* the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Dall, J. L. C.: Amer. Heart J. 70:572-574 (Oct.) 1965. **2.** Liddle, G. W.: Ann. New York Acad. Sci. *139*:466-470 (Nov.) 1966. **3.** Gantt, C. L.: Diuretic Therapy, DM (Disease-A-Month), Chicago, Year Book Medical Publishers, Inc., 1967, pp. 1-31. **4.** Alexander, S.: Geriatrics 23:131-139 (Nov.) 1968. **5.** Stason, W. B., and others: Circulation 34:910-920 (Nov.) 1966. **6.** Lieberman, F. L., and Reynolds, T. B.: Gastroenterology 49:531-538 (Nov.) 1965.

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Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warning: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

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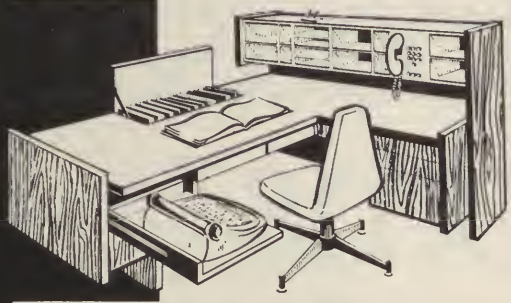
Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children reduce dosage in proportion to age and weight.

How Supplied: Bottles of 50, 500 and 1,000 tablets.

References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961: (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961: (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

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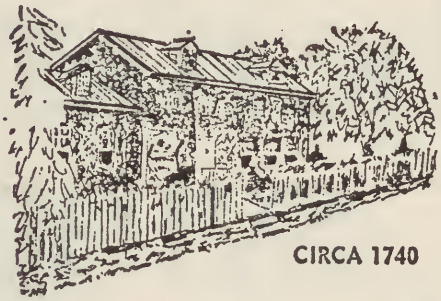
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Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

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See Clinical Considerations section on last page...

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ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

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Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in who serious infection develops, serum concentrations of the drug m rise, with consequently increased risk of ototoxicity. In these p tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine studi of kidney function should be performed when possible. These m be supplemented by evaluation of the vestibular and auditory fur tion and measurement of serum concentration of the drug wh feasible. Serum concentrations of gentamicin should be maintain below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to days or be repeated unless required for serious infection not sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectal may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant a mals have not revealed teratogenic or ototoxic effects in the fet GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisa by the physician.

Adverse Reactions: The overall incidence of ototoxicity conside related to treatment with GARAMYCIN Injectable was 2.8 per c (16 of 565 patients). Contributory factors (two or more factors w relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently ceived other potentially ototoxic antibiotics (streptomycin or ka mycin), and 5 were over 60 years of age. Six also had decrea high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients show increases in BUN that were probably related to treatment w GARAMYCIN Injectable. Of 20 increases probably or possibly rela to treatment, 7 were reversible, 9 occurred in terminal patients, 4 had no follow-up.

Other adverse reactions associated with treatment were one insta each of urticaria, decreased hematocrit, and reversible depress of granulocytes with normal bone marrow. Other rarely repor and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotens convulsions, twitching, salivation, nausea, vomiting, increased tr aminase activity (SGOT or SGPT), increased serum bilirubin, creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-c vials, for intramuscular administration.

For more complete prescribing details, consult package inser Physicians' Desk Reference. Schering literature is also avail from your Schering Representative or Medical Services Departm Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28

Question: What do bullets, cars, and knives have in common?
Answer: These items have produced a rising incidence of bruised, battered and fragmented livers.

The Battered Liver

NEIL NOVIN, MD
Chief, Department of Surgery
South Baltimore General Hospital
Baltimore

Our ability to handle patients with liver injuries expeditiously, and with minimum morbidity and mortality, taxes all of our knowledge and all of our abilities. This is because the liver is such a complex organ.

In fact, it is the only organ present within the individual in which true regeneration and regrowth of new tissue can occur following removal of part of its parenchyma. It even receives a major blood supply from two sources, both of whose minute volume is significant.

During World War II, it was observed by Madding and his group that following a liver injury, a vast majority of individuals showed a large degree of spontaneous hemostasis, most of which occurred prior to the time of exploration. During the early part of World War II, the most significant change in the care of hepatic injuries of the past 25 years occurred.

The previously accepted mode of therapy, ie, using massive packing with long heavy gauze rolls, vaginal packs, etc., with delayed and gradual removal, carried with it a very high mortality and morbidity rate. However, it was soon abandoned in favor of a more direct attack on the specific types of damage found, plus drainage of the areas involved in a posterolateral direction. Accompanying this change in treatment, a much more acceptable death and complication rate was observed.

The majority of wounds sustained by the liver are of the penetrating type. The range of this type of wound progresses from the relatively low velocity stab wound to the very high velocity gunshot wound. All bullet wounds are not alike. There is a great deal of difference between a low velocity .22 caliber target pistol and a high velocity rifle bullet of the same caliber. Yet, there is only a slight difference between bullets of different caliber fired at the same velocity. It is the square of the velocity that is the most significant physical factor in relating the amount of energy imparted to tissue, in relation to the mass and the speed of the missile. $\frac{(E=MV^2)}{2}$

Recent changes in weaponry have been in increasing the muzzle velocity. Our military associates in Vietnam are the major observers of this phenomenon. With the more modern M-16 type high velocity rifles, the damage incurred by bullet wounds today is much more severe than that imparted by a comparable size bullet of yesteryear, including World War II and the Korean conflict.

Civilian life, though, is possibly more hazardous. The civilian arsenal of weapons includes, in addition to the gun and the knife, the automobile.

The higher mortality of blunt trauma can be ascribed to two major factors. First, in the presence of a bullet wound penetrating any body cavity,

Presented under the auspices of the Maryland Trauma Committee of the American College of Surgery during the meeting of the Maryland Chapter on September 6, 1969 in Hershey, Pa., in conjunction with the Semi-annual Meeting of the Medical and Chirurgical Faculty.

there is little, if any, reluctance to surgically explore an individual who has sustained such an injury. Yet there is a degree of delay, procrastination and observation, educated though it may be, that we all go through when we first see a patient who has sustained blunt trauma, before we are convinced that the situation warrants surgical exploration.

Some indication of the mortality rate that can be expected from the nonoperative treatment of liver injury can be garnered from two of many studies that have reached similar conclusions. One from the San Francisco General Hospital supplied by Dr. Madding, and another from Dr. Mikesky, at the Jefferson Davis Hospital in Houston, report mortality rates varying from 62% to 95% in a group of individuals who were found to have had liver injuries but who received nonoperative treatment.

Some authors have stated that not all liver injuries require surgery. This premise requires a good deal of presumption on the writer's part in the absence of exploration, especially since studies, such as those noted above, point out the absolute necessity for surgical treatment of patients sustaining liver trauma.

As recently as 1959, surgeons such as Sloan and Brittain were summarizing the proper approach to the more general problem of blunt abdominal trauma. They stated that the patient with obscure abdominal injury is better treated by early exploration because the diagnosis can be established and the extent of injury more accurately evaluated.

Today, the more conservative point of view is giving way to a more aggressive approach in treating the patient in whom the diagnosis remains in doubt after we have made use of all of our facilities and faculties, including the more sophisticated tools.

The second major factor in relating blunt injuries to a higher mortality rate is the fact that with blunt injuries, severe enough to cause damage to the liver, injuries to other organs often occur. Every major study concerning liver injury clearly demonstrates a progressive rise in the overall mortality and morbidity with each additional organ that is damaged in association with the liver. A summary of these reports showed that a mortality rate of 5% to 10% occurs when the liver is the only organ injured. This rate rose to approximately 20% with another organ injury, and to approximately 35% with two associated organs injured. Reports of 70% to 85% mortality resulted with four or more organs injured in association with the liver.

The pathological processes that are involved in treating liver injuries are: 1. hemorrhage; 2. the products of the liver, ie, bile and bile salts, especially when one thinks about peritonitis secondary to biliary contamination; and 3. any sepsis that may result from either the mechanism of injury (bullet, knife, or bits of clothing) or the operative procedure performed.

These operative procedures, or surgical aspects, include: providing adequate surgical exposure, obtaining hemostasis, performing complete surgical debridement of all devitalized hepatic tissue, and allowing for excellent drainage of the areas of trauma.

Adequate surgical exposure merely means that wounds still heal from side to side across the wound and not from end to end. As long as the exposure is adequate to do what is necessary for the patient and the problems presented, it does not matter what the incision looks like or in what direction it goes.

Following adequate exposure, one must obtain hemostasis and, in doing this, the use of foreign materials, as were mentioned previously, is to be condemned and should be completely discarded, except for their limited use as a temporary expedient during the procedure. This also includes all of the so-called absorbable hemostatic agents, which have been shown by Linstrom in 1955, Blaine in 1951, Hinman in 1949, and more recently by McAllister in 1961, to be not truly absorbable, not truly hemostatic, but which usually function as a nidus for infection or loculation or both. Hemostasis in the liver should be obtained by time-honored methods of clamping and tying, proper application of suture ligatures, and cautery. In a more limited application, cryosurgical techniques, where available, are most useful for hemostasis in liver injuries.

Performing complete surgical debridement of all devitalized hepatic tissue may include, of necessity, major resections or lobectomies. One should, therefore, review what is now known about the anatomy of the liver. Remember that the falciform ligament does not divide the liver into a right and left lobe, but rather divides the left lobe into a lateral and medial segment. Furthermore, remember that the plane of junction of the right and left lobes follows a line roughly 1½ inches to the right of the mid line of the body, passing through the long axis of the fossa of the gall bladder, toward the inferior vena cava as it lies in contact with the liver posteriorally. All of the major divisions of the hepatic artery, portal venous system, and biliary drainage system, basically follow this same pattern as does the hepatic venous drainage, though to a lesser extent.

And last, but by no means least, one must allow excellent drainage of the areas of trauma so that no cavities are left undrained. In discussing drainage, one must include both hepatic parenchymal drainage, which uses various drains, sump pumps, double and triple lumen tubes, etc, and drainage of the common bile duct in major hepatic injuries, so as to insure that no increase in intrahepatic biliary pressure occurs.

With the increasing numbers of trauma cases, more reports of post-traumatic hematobilia are being reported since the first report by Sandblom in 1948. In a 1963 review, Dr. Graff reported that 66 opera-

tions were performed on 20 patients, an average of almost 3½ operations per patient, in which 6 of the 21 eventually died from hemorrhage. Sandblom noted that nonpenetrating lesions of the liver can cause tears in the central part of the liver producing hematobilia. With the number of high-speed automobiles on the increase, we may see more and more of this type of situation.

Reports from other institutions have indicated that prolonged T-tube drainage, in addition to the previously mentioned modalities of treatment, is an important mechanism in helping prevent this most dreaded complication.

Postoperatively, almost all of our analgesic agents cause spasm of the sphincter of Oddi and hence, anticholinergics are indicated to help insure adequate drainage of bile in every direction except into the free peritoneal cavity.

One should be reminded of another physical fact in discussing drainage and that is that these patients remain in the recumbent position most of the time in the postoperative period. A simple rubber drain, stuck through the anterior abdominal wall downward, functions very poorly as a drainage portal, since gravitational forces are far stronger than any physical capillary attraction of even a cigarette-type drain in this anatomical situation. Therefore, it must be emphasized that posterolateral drainage combined with, or in addition to sump-type drainage in the presence of extensive hepatic injury, is necessary.

The surgical approach to hepatic trauma, therefore, can be summarized by a few guides. Do not leave large masses of strangulated tissue or retained foreign bodies within the liver. Do not leave retained segments of devitalized tissue or undrained cavities in the liver. But do drain both the injured areas and the remaining functioning liver tissue after securing hemostasis.

Ancillary measures to be considered both before and during the operation can help protect the liver from the ravages of the injury and subsequent shock. These measures should be considered to make the procedure easier technically.

Hypothermia, which protects the liver during periods of hypoxia, should be used if it is available and the degree of trauma is thought to be significant. It should be prepared for before the patient is placed on the operating room table.

Vascular occlusion of the inflow tract to the liver, using atraumatic clamps in the portal triad, can be of great assistance in handling overwhelming hemorrhage from the liver. These clamps, however, should be removed or at least opened for a few minutes every 15 to 20 minutes unless, as reported by Longmire and others, hypothermia allows a somewhat more prolonged application.

Antibiotics have been reported by some to have been very useful and by others to have shown no statistical significance in changing either death rates or the incidence of complications. However, I feel that in major hepatic trauma, peritoneal lavage, using such things as kantrex or other antibiotics of the surgeon's choice, appear to be a beneficial addition and should be continued in the postoperative period. Lavage of the peritoneal cavity serves as a cleansing or toilet function which should not be disregarded.

Some people have stated in discussing drains that bleeders should be clamped and pus drained. However, as in most cases in surgery, there are no absolutes. I would modify this axiom when it concerns liver trauma and state that in these situations, one should always drain and never be in doubt regarding drainage.

Until a few years ago, resection of a major portion of the liver or even an entire lobe would not have been considered. However, Pack and his group in New York, along with groups in Sweden and Taiwan have in the past 10 or 15 years performed major hepatic resections for varying conditions, including the treatment of the subject under discussion.

In spite of the numerous biochemical and physiological processes that the liver performs, if one gets the patient through the operative procedure, the postoperative biochemical alterations are not insurmountable. However, one must be prepared for some of the more serious abnormalities. One abnormality is the major loss of blood proteins, and another is a severe temporary hypoglycemia, which can be life-threatening.

Significant studies to further delineate these and other abnormalities are now in the process of being reported in surgical literature, the latest study being Dillard's, reported in *Surgery, Gynecology, & Obstetrics*. The two abnormalities mentioned above are relatively easy to handle with the facilities available in most laboratories. They are preventable and treatable with prompt and adequate intravenous replacement. The major difficulties in performing this type of resection, especially in the trauma patient, is the control of bleeding from the very short hepatic veins adjacent to the vena cava, and the prevention of air embolism through these same veins.

Fortunately, formal lobectomy or major resection is only necessary on extremely rare occasions in the treatment of hepatic injury. One should be prepared to deal with it.

It is always reassuring to know that the overall physiological and biological effects of such major operative procedures are not insurmountable and can be handled in most of our general hospitals.

Injuries to the liver, no matter what their inception, can be properly treated today thanks to the efforts of dedicated men, who found the liver not only a complex organ but a challenging one.

It is an interesting paradox that members of a profession committed to the reduction of disease and disability can be so curiously resistant to these same efforts when applied to themselves. But it is true. Physicians are notoriously poor patients. They hate to admit to illness. They minimize or deny its severity. They are slow to seek treatment, and reluctant to accept it. When the help they need is psychological, their reluctance approaches infinity.

Mental Health and the Physician: Who Worries About His?

ROY W. MENNINGER, MD
President
The Menninger Foundation
Topeka, Kansas

Physicians carry burdens and responsibilities which are neither wholly obvious to the public eye, nor readily delegated to someone else. A sense of responsibility for the life of another, an awareness of one's limitations and an apprehension about the consequences of error, and an appreciation of the patient's dependence upon him, are ever-present reminders to the physician of his need to be wise, effective, giving, and capable of carrying the burden of ministering unto others. These same reminders of the need to be strong make it difficult for the physician to manage his doubts and anxieties, and they re-enforce his reluctance to seek relief or support from others.

This lecture, and the three which follow, were delivered at the 1970 Annual Meeting of the Medical and Chirurgical Faculty of Maryland, April 1, 2, and 3. Dr. Menninger's paper was presented under a grant-in-aid from the Merck Sharp & Dohme Postgraduate Program.

Few physicians do seek psychological help of any sort, whether it be counseling, advice, reassurance, guidance, or something more elaborate like psychotherapy or psychoanalysis, even when the problems are compelling. There is little social or personal acceptance for psychological assistance to physicians in momentary need, or in personal crisis. Though both medicine and the public have accepted such concepts of physical prophylaxis as well-baby clinics, annual checkups and the like, there is nothing like this in the psychological realm for either physician or patient. It is still necessary that a physician, who sees a psychologist, be excessively disorganized, addicted to drugs or alcohol, or severely depressed before the justification for his seeking help is at hand.

It is perhaps not surprising that one study has found physicians to use more tranquilizers, sedatives, and stimulants than did a matched control group.

Indeed, abuse of alcohol and mood-altering drugs may be the most common sign of psychiatric illness in physicians. But his need for help is real, if only occasionally acknowledged. How will he recognize it? And where will he find help?

Of these two questions, the first is easier to answer. It will not surprise you to hear a psychiatrist suggest a synonym for that word "help", ie, talk. Talk can be therapeutic for the troubled physician, even as it is for our patients. By verbalizing his anxieties, by talking about the problem which generates them, by examining the alternatives which suggest themselves, the physician, confronted with an anxious situation, simultaneously relieves his distress by the process of talking about it. He facilitates his capacity for problem-solving thought. By transforming feelings into words, feelings become more manageable, less oppressive, and less likely to provoke reactive behavior in the physician.

The second question—where to find the opportunity for therapeutic talk—is harder. It would be well if we had already reached a time when the psychiatrist could play the role of the family physician, as in days gone by. Then his capacity to listen, and to ask questions, could be recognized as a device helpful to the healthy as well as the sick. Regrettably, neither the public nor the practicing physician, nor the psychiatrist himself, is yet prepared for the role that this hope implies. We are not yet at a day where annual psychological checkups are logical and natural. We are not yet at a point where a practicing physician sees the consultative benefit a psychiatrist may have to offer.

Perhaps the next best alternative is to create a group of peers, moderated by a psychiatrist or psychologist, in which the psychological burdens of practicing medicine can be examined, as easily as the psychological problems of the patients are examined in one's practice. Such groups are enormously beneficial, and sometimes powerfully influential for change in healthy directions, but they are hardly universally available. Indeed, not one physician in 100 has access to such a group if he were to want it. But perhaps he could organize it; this I would encourage.

One's wife or one's colleagues are certainly potential sources of assistance, but with limitations in how much one can expect, and how much one can say.

Then, where to turn? Perhaps to be expected, my suggestion will recall an ancient but honorable aphorism: Physician, heal thyself. For indeed, no one else has as much information at hand, so much contact with the problem, or so much awareness of need, as the individual himself. Perhaps our efforts at self-analysis have been less than satisfactory because we have too often asked the wrong questions. Maybe we have failed to diagnose the disorder properly. Maybe we have too quickly asked the question why, or chosen to focus on solutions before we are clear what the problem is.

No matter how available the opportunities for psychological support may be, the physician will continue to live with the special burdens of his practice, and be continually confronted by the anxieties which they bring. My suggestion that we focus on ourselves is likely, therefore, to be a fitting prescription for some time to come.

How are we to go about this? I propose to call your attention to a series of ideas expressed in the form of rhetorical questions, rhetorical because the answers are to be offered to yourself, and not to the public. The questions are intended to be a framework around which you may organize ideas about yourself and your relationships with your environment. Though they are questions which focus on the inner world, they are raised by a psychiatrist. Though they might be considered a kind of "mental health checkup," they will unquestionably strike you as rather nonmedical in nature, and perhaps even more philosophic than scientific. But preeminently, they are pointed and intended to provoke honest thought, which is never an easy task in relation to one's self.

Setting Goals

The first of these questions is perhaps the most global. It invites a review of your life direction. The question I would ask each to consider is this: What are your goals in life? Put otherwise, towards what objectives are you aiming and how realistic are they? How well do they incorporate what is really important to you? And how well do they accurately express your values? Are they for real, or only for show?

The network of interlacing queries arising from the central question provokes several observations. In an era when planning and setting objectives are virtual bywords for every organization, it is ironic to see how few people have adopted the same strategy for themselves. Perhaps we are simply too busy to think about it, too pressured and too overwhelmed by the demands of our daily routine to ever find the time to consider where we are headed, and whence we have come.

Perhaps it is only in late middle age that the lack of a clear sense of direction and the absence of specific goals becomes an appalling reality. Many are those who reach that point in life with a bitter sense of loss and regret. They wonder where time and opportunity have gone. The lack of intrinsic value in the materialistic-oriented goals that some people adopt is obvious, when they helplessly wonder what to do next with their lives, after they have the million dollars that they planned to make. The acquisition of a bigger house, a bigger car, and a

bigger boat, plus all the status that money will buy, has taken on the appearance of a logical goal for many—but does that truly represent their central values?

One cannot think about one's own life goals without asking still other difficult questions. What is, or what are the purposes to which you dedicate your efforts and your lives? What are your personal priorities, and how well does your life's work reflect those priorities? Most of us find such difficult questions easy to avoid, presuming that time will answer them, as indeed it will, though not necessarily to our ultimate satisfaction. Our action-filled lives make procrastination doubly easy, and it is only with the vigor of an intentional decision that we can bring ourselves to stop long enough to ponder such questions. It is to consider just such questions that the benefits of a close, comfortable, and accepting relationship with another person—a spouse, a colleague, a friend, or even a psychotherapist—can be so real. The question is, will you find such an opportunity?

Balancing Priorities

Closely related to that first question about your goals, is one which bears on your use of time and energy. Does your use of your vital resources truly reflect your priorities? Without much thought, most of you would certainly answer "yes," failing to appreciate that for 90% of us the answer is almost assuredly "no."

Executives with broad responsibility are presumed to use their time for the things that are important, such as planning, policy preparation, and making big decisions. With a consistency that is hard to believe, studies have shown that this is rarely true. More often than not, the busy executive is spending 90% of his time on matters that could be done better by others, and are simply a part of the daily routine.

Most of us will recognize in a moment of more somber thought, that the important things in our lives are frequently deferred with a comforting, but self-deceiving assumption that there will always be time tomorrow.

From yet another perspective, there is a high probability that your use of time and energy reflects serious imbalances within the life space of each of you. In spite of public protestations about the importance of the family, about the needs of the community, about the troubles in our world, most of us devote the smallest proportion of our time to these areas. Indeed, it could be fairly said of many of you that you are married to your practice, not your wives. You are invested in your patients, not your children. You are committed to your occupation, not your society.

The point is that these imbalances are decidedly inconsistent with your own statements about what is important and what constitutes your personal priorities. It is this inconsistency which produces a subtle but corrosive tension as your conscience cries out for one commitment, while your activities express another. At times this reflects a distorted conception of responsibility. At times this inconsistency is an impulsive response to the demands of others. Most often it is the outcome of unthinking behavior, the consequence of a general failure to consider your goals, your priorities, and your plans for reaching them.

Nowhere is imbalance in the use of time and energy more obvious than in regard to ourselves. Physicians are dedicated people. For many, this dedication implies, and finally comes to mean considerable self-sacrifice. Time for one's self is discouraged. Pleasure is selfish. One's own needs come last.

Again drawing upon information from a study of executives, less than 40% of some 4,000 executives studied had an avocational pursuit. By inference, they had few sources of personal gratification, and gave themselves few opportunities for fulfilling personal pursuits. Why do they not think better of themselves than that and, are they so different from you?

Acknowledging Responsibility

The third question in my series of rhetorical queries is to ask if your sense of responsibility is also out of balance. In its extreme forms, it is easy to find examples of those who will assume no more responsibility for anything than absolutely necessary. Certainly, the fragmentation of our contemporary culture encourages us to restrict our efforts and our attention to smaller and smaller sectors of the human community. As specialists we demonstrate that same pattern, arguing that the quantity of information is so great that fragmented specialization is inevitable and even advisable. Perhaps it is. But are we guilty of hiding an unduly narrow concept of our responsibility to others behind that rationalization?

Considerably more common in our field of medicine is a pattern that reflects the other extreme. An excessive sense of responsibility keeps us moving like a driven animal. Again, the needs of our patients, the endless calls for our services, make it hard to define a sense of responsibility which simultaneously expresses our commitment to our medical values, and to ourselves, our family, and our world as well. Failing to respond exposes us to the ravages of guilty feelings for failure. Of all the feelings known to the human psyche, guilt is probably the most painful.

It is easy to confuse a concept of responsibility with a command for action, connecting a notion

of obligation with a need to do something about it. When one begins to discover how big the problem is about which he is worrying, his growing sense of helplessness leads him to turn away, disconnect, and assume that someone else will worry instead. A more difficult, but a more effective concept of responsibility is an acknowledgment of the importance of continuing to think about problems and dilemmas, neither turning away in frustration, nor hurling one's self forward into them under the pressure of guilt. Continuing to think about the problems of delinquency in one's community, the need for better school programs for the limited as well as the gifted, and the hundreds of other things for which responsible concern is needed, is a way of staying engaged.

In more personal terms, the concept of balanced responsibility implies a willingness to accept the responsibility for one's own attitudes, feelings, failures, and prejudices. It is worth asking: does each of you demonstrate a readiness to acknowledge your anger, your bias, or your limitations, at least to yourself and to others when this is germane to the situation?

Showing Courage

My fourth query is to ask about your courage, the courage we need to face the internal foe. For we are in most cases our own worst enemies. In the inimitable words of Pogo, "We have met the enemy—and they is us". This kind of courage is exemplified in an ability to look at yourself honestly and fairly, and is an expression of the responsibility I noted earlier. It is not easy to entertain the questions I am posing, without fluctuating wildly between extremes of excessive personal criticism, and total denial that these thoughts have any bearing on you at all. It is this courage which enables us to face, to articulate, and finally to accept our disappointments and losses, one of the most difficult tasks the human psyche faces.

Perhaps this is not so apparent until one stops to realize that life itself is a succession of losses. It begins with the loss of warmth and comfort of the uterus, which nurtured us for the first nine months of our existence. It progresses through the loss of our dependent infant status, the loss of our favorite childhood toys, and the loss of the family, as adolescence separates us from childhood. It is the loss of the irresponsible pleasures of youth with the advent of maturity. It is the loss of jobs, positions, self-esteem, money, and opportunity. It is the loss of one's friends with advancing age, and finally the ultimate loss of life itself. It is something to ponder how extensive is the experience of each of us with loss, big and small, and to note that these are experiences with profound effects upon our mental health. Even as losses vary in their impact upon us, our psychic structure varies in its capacity to handle them, and not all of us do it with equal success.

It has been said that the quality which distinguishes a great man from another like him is his capacity to manage disappointment and loss. One thinks of the experiences of Churchill and the crushing disappointments of his early career, or those of Roosevelt with the disabling onslaught of polio, and begins to realize the wisdom in that observation.

Accepting loss is accepting the reality of it, and then coming to terms with its meanings. Doing so is vital, if the spirit is to continue to grow, and in some cases even to survive. It is relevant to note that the successful rehabilitation of a person newly blind depends upon his first having accepted the reality of his loss of vision, in a process of mourning akin to grieving the loss of a loved one.

It brings me to ask: what can you say about your courage to face and to accept the anguish of loss?

Managing Stress

Germane to any assessment of our mental health is a look at how we manage stress and anxiety. Both are ubiquitous and unavoidable parts of human existence. Each of us has variable reserves and differing means for managing these painful qualities of life. Our methods of managing anxiety are often inefficient, expensive, and even self-defeating.

There are those who deny its existence, others who reject or displace it external to themselves. For others, anxiety provokes acting out, with resort to alcohol, sexual promiscuity, gambling, excessive spending, or frenetic activity. As physicians, we are aware of the frequency with which physical symptoms themselves may be somatic expressions of stress. Are you aware of this pattern in yourselves? The anxiety of responsibility commonly produces an introjected style of managing stress, which provokes depression, a pervasive sense of inadequacy, and even suicide.

The ability to live effectively and compatibly with degrees of tension and anxiety is a mark of emotional maturity. For each of you it is worth asking how well you perceive your own styles of managing stress. How accurately do you characterize it? How able are you to alter it, towards methods which are more effective, less expensive, and less self-destructive?

Examining Relationships

The sixth query is to ask that each physician examine the consistency and the quality of his personal relationships. Most of us accept the truism that people are important to people. Yet we fail to perceive how often human relationships are superficial, meager, and unrewarding. Is this true of you? Which of your relationships can you say has as its essence a quality of involvement with the

other, expressing a depth of emotional investment, which is real and mutually experienced? It is again too easy to explain that the pressures of our lives, and the demands upon us, the superficial materialism of the age and all the rest, are what account for a deep sense of poverty in our relationships with others. To call again upon that element of courage to which I earlier referred, can we examine the quality of the relationships of those who are closest to us, to question how honest, how open, and how real they are?

It is clear that the capacity to establish emotional ties with others is characteristic of emotional maturity. It is clear, moreover, that the work, the effort, and sometimes the pain of doing so is quite enough to discourage many, especially when the trends in our society are moving in the same direction. Yet we are all disdainful of the empty superficiality of the cocktail party, even when it is lessened by the illusion of intimacy, which alcohol can provide.

The phenomenon of parallel play in the nursery school—two children in close physical contact with each other but playing entirely alone—is expectable at the age of two or three. When it can be said to characterize a pattern of living at the age of 20 or 40, it hints at relationships eroded by infantile expectations, and a lack of mutual commitment. Relationships which show a depth of emotional involvement require a willingness to engage, to share, to listen, to give. What can you say about these qualities in your human relationships?

Seeking Support

Not unrelated to a question about your human relationships is a query about sources of your emotional support. From whom do you receive it, and to whom do you give it? I have referred to the lack of fulfilling avocation in the lives of many executives. Does this also describe you?

It is also clear that many people who are imbued with a strong sense of responsibility, many of whom are physicians, have great difficulty in seeking or accepting support from others. For some, this is reminiscent of a profoundly unpleasant sense of helplessness from an earlier phase of life. For some it is an unacceptable admission of weakness or inadequacy, or a contradiction of one's sense of strength and commitment to help others. Ironically, those whose careers lead to increasing reponsibility for others must provide increasing support for others, at the very moment when they are less able to ask for help for themselves. Greater responsibility generates greater personal need, and greater obstacles to receiving it.

The plain fact of the matter is that physicians have dependent needs too, all of our efforts to deny, to rationalize, or to minimize them notwithstanding. We need not pretend otherwise. Some attention to the problem, and some recognition of its existence, is a beginning step in a search for ways to meet our dependent needs, with neither sacrifice to our self-esteem nor compromise of our sense of adequacy. May I remind you again of the importance of a warm and intimate relationship, which permits you to talk about the needs which are there clamoring for fulfillment, but difficult to recognize and embarrassing to acknowledge.

Giving Love

Finally, any survey of your mental health must ask about the role of love in your lives. For most of us, the very use of this word threatens a deluge of sentimentality. It is a word which too readily conjures images of Hollywood and technicolor, cow-eyed adolescents, and the *Ladies Home Journal.* But it is a respectable feeling, and one which forms an important part of the apostolic junctions of the physician. I use it to refer to a capacity to care. For many of us, this is a vital quality in our work with patients. Perhaps we are less aware, however, that it implies a willingness to invest ourselves in others, to be involved with them, to listen to them, in short, to care about them. It should be a hallmark of all our relationships with others. This is the true sense of helping. It is not only the only antidote to hate that we know, but it is also the foundation for that indispensable pillar of human relationships, trust. Both love and trust are always in short supply, but surely no group and no profession is as aware of their importance as is the physician.

Without appearing to promote egocentricity, I would have to ask how truly and how well you love yourself, not in irrational and overblown terms, but as an object of pride and self-esteem, a thing of value, a person of worth. As one can love himself in this mature and realistic way, so he is able to extend the help of love to others, in ways which are not demeaning, not controlling, not condescending or patronizing, but respectful and genuinely caring.

Your relationships to others do indeed mirror your relationship to yourself. How well you deal with others may depend upon your success in managing yourself, in relation to the provocative and difficult questions that I have posed. No one has suggested these questions are easy, in some sense they may be unanswerable. But they do need to be thought about by each of you, talked about with those you love and are close to, and examined repeatedly in the months and years ahead.

Acknowledging the compelling qualities of the irrational in the lives of all of us, Freud once observed that our best defense was our intellect, for as he put it, the voice of the intellect is weak but persistent.

Amos R. Koontz, MD, Memorial Fund Lecture

The Future of Medical Education

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The medical school of the future must accept the responsibility of leadership at the apex of a large pyramid of health and medical curricula for our future health workers. The medical school must play this role within its university and for its community.

Between 1900 and 1964 there was an appreciable decrease in the number of agricultural workers per unit of population.[1] Apparently during these decades our agricultural workers became six times more productive. Let us compare this with health. During the same 64-year period, there was a sixfold increase in the number of health workers per unit of population. Does this mean that our health workers have become only one sixth as efficient? Of course, the true explanation involves the enormous increase in the complexity of medical care. In addition, the unmet needs in health have never been so apparent and the techniques for their solution have never seemed so ineffective and so costly.

The underlying reasons for this discrepancy are obvious. Suffice it to say that medicine has achieved successes which have forced it to confront serious problems that it has not yet learned to solve. The medical armamentarium is becoming more complex and costly since we keep people alive longer and they have more time to suffer more long-term diseases. The increasing education and affluence of our society has increased the visibility of medical need and the stridence of the citizen demands for the requisite care.

We are facing a grave medical care crisis in our society. There is no obvious end in view to the upward spiral of recognition of need, demand for and cost of care. No single plan yet offered or suggested to the American people is the real answer.

What we tend to forget is that it will take time for our civilization to solve its problems. Presently,

there is no available panacea for our health crisis. But there are steps which can be taken now, serious and thoughtful steps, which will lead us on toward ultimate solutions. There are programs which we can think through and develop that will put us in league with the future. These programs will make it possible for us to maximize our present resources and to take the greatest advantage of any new resources our successors develop.

All health programs will require the education of health manpower. Although manpower is not our sole need in health care, it is one of the most crucial and one that is particularly sensitive to any change in federal and state health programs.

The medical school of the future must accept the responsibility of leadership as part of its curriculum for our future health workers.

Some people are deeply concerned that the university must take leadership in such a practical matter. They fear the consequent weakening of our protected, ivory-towered seats of learning. This is a real danger, and the responsibility must neither be offered nor accepted lightly. Yet the public interest demands it—there is no alternative.

The major justification for assuming leadership lies in the nature of the medical care crisis today, and the ultimate hope for its solution. The overall assessment of the present state of medical science in relation to our present killers and disablers must be that at best, it is inadequate.

Medical care is not definitive, because we do not have the requisite scientific base from which to launch crucially effective programs against heart disease, stroke, cancer, arthritis, mental disease, diabetes, nephritis, cirrhosis, diseases of the newborn, and many more.

True, we do help many patients, we do cure some, but our total effort is inadequate to check the present and future case loads. We can promise no large number of new lives that will be saved per unit of new medical care provided and, except in the worst areas of our country, we cannot make a case for a definitive new contribution of selected increments of more medical care.

Under such conditions the essence of progress relates to the improvement of the substantive part of medicine, the product itself. The fruits of new research are required to improve this product and must be rapidly established as part of that product. Therefore, the medical school and its parent university, which sponsors most of the biological research now being undertaken in this nation, is uniquely qualified to take this leadership. The school can lead by supplying the most current definition of "quality" in medicine. We will never solve our medical care crisis until we achieve better quality in medicine. Equality, as outlined in such programs as medicare, medicaid, comprehensive health planning and universal health insurance is important, but it is not, in itself, crucial. Only a future drastic improvement in the quality of the content of medical care itself can be definitive.

It becomes apparent that the deep involvement of the medical school and its parent university in teaching health manpower is essential. Creating the various members of the health team, training them, retraining them, encouraging career mobility, and presenting effective models for the operation of such teams are the functions that the medical school must perform.

It has been reported by everyone looking into the future that we have and will continue to have major shortages in health personnel. Even the enthusiastic devotees of universal health insurance admit that the passage of their favorite legislation would result in tremendous pressures upon existing manpower. The physician augmentation program has received top federal priority, but to date its efforts have borne little fruit. The struggle must continue.

There is also a real danger that the allied health professional field will grow unplanned, uncoordinated, and maybe even unusable. Leadership by the university is sorely needed here. The proper utilization of many groups requires changes in various state medical practice acts. The licensing of these new categories of health workers should involve their membership in a team, working under medical supervision.

It would indeed be a sad commentary on our struggle for real answers if we created vast new entities of solo health practitioners, pursuing a fragmented program at a lower level of health quality than was ever permitted before. This could be the end result of the blind pursuit of equality of access to care, through the creation of an army of allied health workers operating on the basis of present practice mechanisms.

Therefore, let me outline the various categories of medical education, which I hope will concern the medical school of the future.

At the apex of the pyramid will be the continuing education of the physicians of the community. I predict that this program will eventually become the most important function of the medical school. With the rapid advances in modern medicine, re-education becomes a necessity. Eventually, other specialty boards will no doubt follow the example of the American Board of Family Medicine and require re-examination every six years in order for one to be eligible to retain his status as diplomate. State licensure may even be changed to require periodic relicensure in one's medical specialty. Some states have done this for automobile drivers' licenses. Certainly the inadequate physician presents a greater social hazard than does the poor driver.

Physicians in the community will be taught in

effective postgraduate education programs, sometimes playing the role of teacher, sometimes that of student. The instruction will include much more than a few films and lectures. Hopefully it will be practical, serious, and persistent. Whereas undergraduate medical education involves a program of four years, and residency an additional four to six years, postgraduate education will continue for the professional life of the physician—30 years or more. Hence, our finest teachers, our best facilities, our most elaborate efforts, must be given to this program, which is a challenge that few medical schools have yet accepted.

These programs are one answer to the growing threat of iatrogenic disease, whose increase, I feel, will be a logical counterpart to the sharp upward sweep of medical care for the masses. Peer review mechanisms are almost surely coming. These reviews must not merely be embarrassing checkups searching for errors, incompetence, overcharging, overutilization, and other iatrogenic difficulties. Rather, they should be inherently constructive, corrective, educational, and generative of an improved quality of patient care. In short, they should be a real part of postgraduate education.

Refresher courses are becoming essential for today's practicing physicians. One such course conducted at Mount Sinai, a biochemistry overview for practicing physicians, had 50 students attending regularly and faithfully for months. These students, all members of a regular attending staff in the clinical specialties, were quite vociferous in their praise of this program.

Another program which will be of importance and magnitude will be the training of interns and residents. Our future medical school will be associated with a large number of affiliated hospitals. All of the house staff of these hospitals will comprise the student body for an academically-oriented program of graduate medical education.

Any hospital not affiliated with a medical school should be permitted to train the house staff. Such training is part of an academic milieu, not a mere apprenticeship for practical efforts to continue the same varieties of medical care.

The training program should be fully academic and far broader than the usual specialized instruction in knowledge and clinical skills. True academic pursuits should be available. For example, this is the period when the young physician, now closest to his final career specialty, may feel the need for special work in medical economics, computer techniques, group practice, medical care in the ghetto, forensic medicine, medical ethics, biostatistics, and sociology. Certainly he would find such work far more relevant to his immediate future than he would have in his undergraduate medical school days.

By admitting the student for graduate medical education into the medical school rather than into the hospital, the program can be labeled what it should be—an educational one. Moreover, the medical school is in the best position to arrange the most productive rotation plan throughout some of its affiliated institutions, when required for the proper training of the student.

A core of academic courses with a wide choice of electives can permit many residents from different specialties to share certain common general courses. Opportunities for work with community medicine projects would be particularly useful for the future physician, who will face a strong "consumer market" during the coming years.

The next level is that of the undergraduate medical student. Despite the volumes written on the medical curriculum, this curriculum still remains remarkably similar and uniform. Faculty and students can move freely between existing American medical schools and quickly adjust to any so-called innovations which they find.

Current pressures exist for less core programs and more electives; more humanities, community medicine and ecology; earlier career choice in medicine with the early elective of a specialty track; earlier presentation in the curriculum of clinical material; and various programs to shorten the entire period of time for collegiate plus undergraduate education.

Each of these proposals is either presently being applied or is under serious consideration in the medical schools. Each has interesting implications, and several make the stay at medical school more interesting and more adaptable to the individual needs of the student. However, none appears to be crucial to the development of a new physician for the future.

Perhaps the task of the greatest significance to the medical school dean of the future will be that of coordinating the program of undergraduate medical education with other programs. For example, if it is true, as some of us believe, that the new physician will be called upon to act as the captain of a large and complex team of allied health professional workers, then his training program should include a familiarity with the techniques of administration as well as a practical familiarity with what each member of the team can do.

The medical student must also learn the importance of research and development. We must never let the medical student forget that the most poorly trained nurse who holds a syringe of penicillin in her hand is a better physician for the treatment of the patient with lobar pneumonia than was our greatest internist in 1938. Let us not forget that some equally poorly trained health worker in 1990 may well be better equipped to deal with heart disease, stroke, and cancer than we are today.

The student must understand that our only hope

for a major impact upon mankind's diseases lies not in more physicians, not in more allied health workers, not in more and better programs for the delivery of medical care, but in future research. I was appalled recently to receive a set of early questionnaire returns from practicing physicians suggesting that the nation's research effort should be rather sharply curtailed. I trust that our new generation of medical students will not be so inclined. If the profession itself does not search for real answers to the riddle of our major diseases, then indeed, who will?

Another attitude, which we must foster, is the need of the student to be concerned with unmet community needs. While the medical school cannot be responsible for meeting all of these needs, its faculty and students should be aware of all of them. They should be involved with ways of improving the delivery of quality care.

There is an area in South Bronx, New York, which in 1938 had 25,000 people and 50 physicians. It now has double the population (50,000) but only 5 physicians. Such matters must be of concern to medical students. They as physicians will be called upon to provide leadership in solving such problems.

Certainly we are derelict in our duty as teachers if we fail to point out the inadequacies in our health delivery system, and the challenges which exist in attacking it and in providing useful solutions. This is why I feel so strongly that every medical school must have a very strong department of community medicine, engaged in an active program in its community.

Among the allied health professional workers, the elite groups are composed of those with the higher academic degrees. While doctoral degrees are rare and limited to those with teaching duties, there is a small indication that this will change. The doctoral degree has been urged as a reward for unusual technical skill coupled with a great intellectual understanding of the medical care subject. Certainly there is no categorical reason why a doctoral degree should not be given to a nurse who is highly skilled in complex clinical procedures such as cardiac care or renal dialysis.

The master's degree is, of course, a fitting step along the way. As a recognition of very high technical skill and knowledge, coupled with the ability to administer other workers, the master-trained person can take over a large amount of independent responsibility.

The training programs, even if they are designed for people who will fill administrative posts, must give emphasis to the substantive part of medicine.

We at the medical school here at Mount Sinai participate actively in a master's level program at Baruch College in medical care administration. We insist, in this joint program, that the student have rather extensive training in the substantive side of medical care. We believe strongly that a person should have a reasonably good knowledge of what it is he is administering. He should know what the differences are between good and poor care, what the defects are in our medical knowledge, and why research is a priority. He should also know how to organize programs to improve the quality of medical care, and what new medical care complexities are ahead.

We want our new unit administrators to be capable of much independent judgment and initiative. They will soon be administering major neighborhood health centers, rural health centers, group practices, multiphasic screening programs, home care, and extended care programs. Their role is a far cry from the familiar one as handmaiden to the practicing physician, within the confining walls of a large general hospital.

The major traditional baccalaureate program in the health field is nursing. We can, of course, find AA programs, RN programs, and even LPN programs. Our own medical center includes examples of each. Our Mount Sinai RN nursing program, one of the oldest in the country, was turned over to the CUNY college to be run as a baccalaureate program. It is also developing a series of master's level programs based primarily on clinical excellence and specialization. Our affiliate hospitals have the other varieties of nursing programs. We are now in a position to develop working teams of nurses, dovetailing the various types into a single organized unit. Once the nurses settle their own very special role-playing tasks harmoniously, it should be much easier to allocate the remaining tasks within the medical care team.

At CUNY we have another major health manpower effort at the baccalaureate level. This is the Hunter College Institute of Health Sciences which, in cooperation with our medical school, trains people in a rapidly growing number of specialties. Although careful attention is given to these specialties, there is a good solid common core of basic medical science for all of them. Among the present programs are: radiotherapy technology, physiotherapy, health education, communication science and communication disorders, environmental science, and, now in development, the physician assistant.

A unique feature of this program is the large amount of instruction which is given by the staff of the medical school. Although the total effort has only just begun with about 50 students for the year, we estimate that our medical facility has already given over $100,000 worth of academic time to it. There is no reimbursement for this effort.

One particular aspect of this baccalaureate program at Hunter College deserves special comment.

There are two ways to gain admittance to the school. The usual way is directly from high school. But there is another carefully designed curriculum, which can accept the graduate of one of CUNY's community colleges. Such students may be relatively strong in practical techniques but weak in theory. Hence, a curriculum, tailor-made to their needs, has been established.

CUNY has numerous community colleges with huge and still growing enrollments in the health fields. While our medical school makes no attempt to embrace this enormous group, it does have two unique responsibilities.

One of these community colleges, Hostos, has been allocated entirely to the training of students in the health careers. This school is a tight affiliate of the medical school. It is from its students that we hope to round out our medical care teams and to teach all of our medical and allied health students the new patterns of medical care delivery for the future.

There is a grave danger that current pressures in the health field will lead to uncoordinated programs of health training. Already we have seen strange programs develop, such as the community college arrangement to train orthopedic assistants. Moreover, several programs were planned for community college, baccalaureate, or master's levels, with no basic essential differences between the curricula. Clearly there is a need to bring order to the scene.

In response to this obvious need, the chancellor of CUNY has created a special university-wide curriculum committee for the health programs. The chairman of the committee is the dean of the medical school. Its membership includes representatives of college presidents, health program directors, and practicing physicians from the community. Its role is advisory, but its recommendations will no doubt be followed in the great majority of instances.

An important feature of all community college programs is the initial necessity to plan a continuous education effort. Technological obsolescence is a reality to such graduates. The community college must accept the responsibility for their retraining.

Mention has already been made of the problems posed by the medical practice acts in virtually all states. It is essential to our future efforts in total medical education that there be a careful re-examination of each such act. This re-examination must be performed by the largest possible number of involved groups and it should have the strongest of medical leadership. We have already noted the great risks we run from too loose a construction of these acts, which would permit large numbers of new fee-for-service entrepreneurs, with low levels of training, to flood our cities and rural areas.

Equally dangerous would be a narrow construction that would not utilize physician's assistants or not allow them to move freely between states. Perhaps what we really need are less legislative restrictions and more delegation to a public body composed of distinguished physicians and laymen. This body would adjust the rules to fit community health needs on the one hand, and maintain and improve health quality on the other.

Of almost equal significance to the need to overhaul our medical practice acts is the need to overhaul the field of malpractice. The judgment of the quality of medical care must somehow be removed from the courts. No doubt it is our own fault that malpractice decisions have gotten so far out of hand. The medical profession has been unwilling to accept the burden of deciding quality among programs, physicians, and actual physician services. I mention malpractice in the educational context, because it is a vital modifying force.

I definitely believe that medical care programs of the future will involve medical care teams composed of many varieties, and many levels of health professionals working under the leadership of a physician. The pressures for more medical care make it unlikely that any other solution will be as effective. Studies have already shown that this is feasible and that patients will accept it. At The Johns Hopkins, a recent study showed that the residential ghetto-type population was quite willing to accept a primary health visit by a nonphysician member of the team.[2]

At Kaiser-Permanente it has been found possible to screen a patient for a large number of clinical conditions with essentially no medical input for as little as $20 or more for a 2½ hour workup.[3]

The physician is thereby given an extensive profile on his patient, making his time with that patient more efficiently spent. Examples will continue to grow as rural health centers, neighborhood health centers, extended care facilities, and home care programs increase to meet the huge unmet health needs now becoming well recognized.

As these efforts continue, as our population and our governments become more aware of health needs and programs, I expect the medical school to take more leadership. This leadership will extend far beyond its traditional responsibilities to train medical students. It will embrace the entire gamut of the training and retraining of all of the categories of health professional workers.

REFERENCES

1. Greenfield, H. I.: Manpower Problems in the Allied Health Field. 64th Annual Conference on Medical Education sponsored by the AMA Council on Medical Education, Chicago, Ill., February 11, 1968.
2. Densen, P., et al: Primary Medical Care for an Urban Population: A Survey of Present and Potential Utilization. *J Med Educ* 43:1244-1249, December, 1968.
3. Collen, M. F., et al: Cost Analysis of a Multiphasic Screening Program. *New Engl J Med* 280:1043-1045, May 8, 1969.

Harvey Grant Beck Memorial Lecture

The Emerging Physician's Assistant

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A crisis exists in the delivery of medical services. In order to combat this crisis, and amidst much controversy, the physician's assistant is emerging.

We, as physicians, have the background of medical education and experience necessary to lead the country in making wise decisions in solving the problem of the delivery of medical services. To do this, we must get involved in educational innovation and in experimentation, which is necessary if we are to adapt our rapidly expanding medical science to the changing socioeconomic conditions of our time.

The medical profession has responded to the challenge to extend health care in many ways. Perhaps the most unique, rapidly growing, and controversial program has been the one for the development of a highly-trained assistant for the physician. The first was a two-year program for medical corpsmen started at the Duke University Medical Center by Dr. Eugene Stead in 1965.[1] There are now 40 or more programs, either in operation or being developed. The educational setting, the curriculum content, the length of the program, and the title given to the graduate vary quite markedly. The following

applies to our own program and our experiences with it at Alderson-Broaddus College and Broaddus Hospital.

Reacting to the need for expanded medical services in our area, the trustees and the medical staff of Broaddus Hospital approached the president and officials of Alderson-Broaddus College in 1963 and proposed an addition to the existing allied health programs of the college: a baccalaureate degree program for medical assistants. A committee representing the two institutions met several times to discuss the matter, but made little progress. In 1967, a new committee was formed and a plan for action was agreed upon. Many medical educators both inside and outside West Virginia were consulted. It was the opinion of one of the consultants that the title of this proposed new professional should be "physician's assistant", since this term would be more descriptive of the level of education that was planned for the type of allied health assistant that we would be graduating.

Definition

The physician's assistant is a health professional who works directly under the orders and supervision of a physician. He is educated for this role by taking and completing a series of liberal studies, along with didactic courses and clinical experiences in the medical sciences. His educational encounters stress the need to identify with physicians in modes of thought, patterns of action and reaction, and dedication to moral and ethical value systems. To become professionally competent, he must ultimately achieve the mind-set of the physician. His education is broadly based. He possesses a comprehensive concept of the nature of illness and, because of this, he can intelligently assist the physician in countless ways. The majority of his assignments, however, are concerned with performing more routine or less demanding, yet time-consuming tasks which have traditionally been the work of the physician himself.

The architects of this educational endeavor were three physicians, one educator, and one psychologist under the supervision of, and with the help of, seven other physicians, the college president, a sociologist, a chemist, a minister, four nursing educators, two hospital administrators, and twelve well-known national consultants. These people represented the college administration, the council of the West Virginia State Medical Association, the West Virginia Nurses Association, and the West Virginia University School of Medicine. The consultants were chosen from national organizations or from other medical schools.

Scope of Duties

The physician's assistant, as conceived by the group of designers, would:

1. Take the patient's history and record other patient data.
2. Carry out screening types of routine and special examinations.
3. Do assigned ward work of the physician.
4. Make hospital and nursing home rounds as requested by the physician.
5. Render or assist in first aid in the hospital emergency room or elsewhere.
6. Order laboratory studies, X-ray examinations, etc, as directed by the physician.
7. Assist the surgeon in the operating room, cast room, and elsewhere.
8. Give research assistance as outlined by the physician.
9. Supervise administrative work which may require medical insight.
10. Do certain technical procedures in the absence of a technician.
11. Conduct educational programs such as teaching aides, etc.
12. Instruct patients in their home-care procedures.
13. Carry out such other clinical and research procedures as the assistant's innate ability, plus his education and training permit him to undertake under the guidance of the physician.

The objective sought by such a role was the improvement and extension of patient care. The committee members who worked on the development phase of the program felt that the assistant, who would fulfill this role in an adequate manner, would relieve the physician of at least 30% of his work. This would enable the physician to care for more patients, do additional studies, and carry out research projects.

The question arose as to whether a new occupation should be developed or whether existing ones should be expanded. The only group that could be expanded to fill this unique role without an excessively long period of training seemed to be the graduate nurse who would take additional courses in history taking, etc.

The idea of using nurses for physician's assistants, however, did not seem to be feasible or desirable because nurses are already in short supply and they are also seeking to develop a new role of their own in patient care. A program which could develop a male image, but not exclude females, was thus chosen.

The Need for Assistants

Physicians, like all other people who accomplish much, must be aided by assistants. This was true in ancient times, and it has been increasingly im-

perative as medicine has progressed from the status of an art, to that of a highly sophisticated science, albeit biologic in type and still mixed with a liberal amount of art.

The growing proportion of science in medicine has posed two problems for the profession: 1) How can the accumulated fund of scientific facts be mastered and applied? and 2) Is it feasible and acceptable for an assistant, without an MD degree, to assume some of the role and function which has previously been the sole prerogative of the physician himself? In the past, part of this dilemma has been solved by the fragmentation of medicine into specialties and subspecialties. This is only partially effective in solving the problem, and it soon becomes confusing to the patient and also expensive for him if it is carried to the extreme. Poor practice can result if the patient starts choosing his own specialist, and he no longer secures an appraisal of the overall picture which comes with a general physical examination.

The limiting of practice to a specialty has not decreased the need for assistants because knowledge in the various branches of medicine has developed too rapidly for this effect to occur. The accumulated facts about all specialties are now voluminous. For example, Campbell and Harrison's *Urology* covers 2,800 pages and this material is in an abbreviated form. The subspecialty of gastroenterology as presented by Bockus covers 3,550 pages, also in the form of a summation. When one wants comprehensive data on any of the parts of these specialties, he must read dozens or even hundreds of papers which cover research into the minute details of the particular small area in which he seeks information. It, therefore, becomes apparent that the physician who is attempting to treat patients thoroughly or do research in any field, must have efficient assistance in the gathering of facts.

Acceptability of the Assistant

This brings us to the point of acceptability. Will the patient accept a physician's assistant? Will the physician accept him? Patients have accepted assistants such as medical technologists, radiologic technologists, dietitians, occupational therapists, etc. They have also accepted independent practitioners such as nurses, pharmacists, podiatrists, optometrists, and others. People abroad have accepted independent practitioners of medicine educated on a lower level such as the Russian-Feldsher and the Assistant Medical Officer (AMO) [2] of some of the developing countries.

Pondy [3] and his associates interviewed 72 patients of four physicians who employ assistants to determine the degree of acceptance of the physician's assistants as legitimate members of the health team. They found that there was moderate to high acceptance by 71% of the group and low acceptance by 29%.

Acceptance was largely linked with education and income: It was high in the middle income group and low in both the high and low income groups. It was low also in the poorly educated group. Acceptance increased with the number of years of formal education of the patient. It was high in the small community clinic, apparently because of the shortage of physicians in the rural areas. However, the most important of these factors seemed to be the level of education of the patients. As their education grew, patients were better able to understand how properly trained assistants could help a physician deliver better health care, probably at a lower cost.

Will physicians accept assistants who are trained to do some of the time-consuming work which they alone have been doing in the past? This is a question that cannot be definitely answered at present. However, there are some indications that many of them will. Some of them are enthusiastic about the prospects of obtaining adequately trained assistants while others are hostile to the idea. The best study of physicians' reactions to date seems to be that of Coye and Hansen,[4] who surveyed the 4,000 members of the Wisconsin State Medical Society who were participants in workman's compensation panels. Adequately completed questionnaires were received from 1,345 physicians, 1,299 of which were suitable for computer processing. Sixty-one percent of the respondents believed that assistants were needed; 42% stated that they would use assistants in their practice.

One of the results of this study was the marked difference of opinion as to what the assistant's responsibilities should be. It is natural that this feeling should develop since the movement to produce such an assistant seems to be a minor revolution in medicine. For opinions to be of most value, they must be gathered from a wide variety of sources and sufficient time must be given for opinions to become firm and objective.

It has been interesting to note the changing reaction to the physician's assistant in our own institutions. At first, there was moderate hostility to the idea by many nurses and some physicians. This was discernible when the first students and the first trained assistants arrived on our campus and in our hospital. This hostility rapidly disappeared. In some instances, outward evidence of it completely vanished within a few hours when the trained assistants demonstrated their role in patient care and their competencies in carrying out their assignments or studies, and when, as students, they showed their eagerness to learn and cooperate with physicians, nurses, and allied health personnel.

One frequently voiced reason that some physicians have opposed the idea of training physician's assis-

tants has been that such skilled allied health professionals might try to set up independent practice situations and begin the practice of medicine without a license. This matter has been discussed with the secretary of the Medical Licensing Board of West Virginia.[5] In general, he stated, those who have tried to practice medicine without a license in West Virginia have not been people who have had formal training or education in the allied health fields or even people with college degrees. Rather, most of them have been poorly educated persons or ones with character defects.

In a recently published book on medical licensure, Derbyshire [6] states that the typical successful imposter has a medical background that might consist of a tour of duty as a medical corpsman in the army or as a pharmacist's mate in the navy. He may have been a hospital orderly, a laboratory technician, an elevator operator in a hospital, or even a patient in a mental hospital. From the frequent contacts with physicians which the future imposter thus has, he develops a medical jargon sufficient to fool the unwary.

The students for the physician's assistant curriculum are chosen for intelligence, honesty, integrity, and devotion to duty. They are grounded in the history, philosophy, and ethics of medicine. Every attempt to motivate them to achieve excellence in their pre-professional and professional work is made. They are made keenly aware of the fact that medicine has reached a pinnacle, and that to remain there and go higher, the education of physicians and their associates and assistants in the allied health roles must be constantly revised in an effort to increase their funds of knowledge.

Each one is encouraged to improve his status by additional education, but only through professionally recognized channels. An attempt is made to evaluate the potential of each student, not only before his entrance into the program, but at various times during his college career. From these evaluations, he is offered counsel regarding his remaining in the department, changing his major, or seeking graduate study after his program of studies has been completed.

It is believed that a person who is educated in this way, and survives the many tests of intelligence, competence, and character that the training brings, will be much less likely to violate his code of ethics and the law by starting independent practice than a person who has not been subjected to this type of moral and educational discipline. We feel that any student who has defects in character, competency, or personality adjustment can be detected and eliminated from the program long before he has completed it.

After the preliminary decisions were made, and the necessary educators were secured to do the planning, the college started on an uncharted course to construct an integrated program, one which would give the student the necessary broad range of general as well as professional education courses to enable him to: (1) understand the basic principles of what he was to do and not just how to do it; (2) understand the complex nature of the individual human personality and the social context within and through which he must function; and (3) develop a personal value system which would tend to insure his success in his professional role and function.

It was thought that this would require a combination of liberal studies, professional studies, time for maturity, and the building of a sense of professional responsibility. The development of what is meant by the physician's "mind-set" and other such broad comprehensions are rather long-term educational undertakings. Four years does not seem too long a time in which to securely lay such foundational concepts.

In its report, the Committee on Curriculum Development said, "The contributions of the liberal arts to the student's preparation become functional, as they aid him in comprehending the relevance of mankind's major problems. Illness involves much more than the purely physical.

"Medical science has already demonstrated its understanding of this by making provisions for broad baccalaureate educational requirements for certain types of allied medical personnel, other than physician's assistants. Are their needs and those of the patients with whom they work less demanding than those of other assistants? Will sheer technical competence alone suffice to meet such needs? The college believes not.

"Effective liberal, as well as quality professional education must characterize the program of studies of the physician's assistant. The contributions of these areas must not be segregated. Each must operate upon the other in complementary modes. Therefore, the educational values to be obtained through correlating the general and professional aspects of the curriculum are, in the opinion of the college, best realized through a program in which both areas are simultaneously experienced."

Thus, the foundation for the construction of an integrated program of liberal and professional studies was laid, and the committee, with the help of specialists in various fields, outlined the new courses which needed to be developed, and the clinical experiences which were necessary. After that, the structure of the curriculum was tentatively completed. The committee recognized the fact that changes would become necessary wherever weaknesses were found. This has proved to be the case in a few instances, but there have not been as many as were anticipated.

In September 1968, we admitted our first class of 30 students. We were fortunate in being able to attract students who, for the most part, possessed

the qualities which we felt would make them good physician's assistants, ie, intelligence, honesty, integrity, and cooperativeness combined with energy, loyalty, and service motivations. We started the spring 1970 quarter with 20 freshmen students and 18 sophomores. Twenty-seven of these were young men and women without military experience and 11 were former medical corpsmen. Twenty-four were men and 14 were women—a proportion which indicates that this profession is already developing a male image here and can be expected to attract men who would probably go into a nonhealth field if this type of educational program were not available.

We have been alert to the appearance of weaknesses which have developed during the first two years. We have observed closely not only students, but also some nondegree graduate physician's assistants who have transferred to our program and who have been acting as part-time clinical assistants while working on their degrees. As a result of our observations and experiences we have learned the following:

1. That the difference in the role between a physician's assistant and a nurse must be clearly defined. We have given this question considerable thought and have decided that the nurse is concerned primarily with personal medical care, whereas the physician's assistant is concerned mostly with diagnosis.

2. That where the role of the assistant overlaps that of other allied health personnel, a clear division of responsibility must be made. This has been resolved by assigning primary responsibility for specific tasks to one group and secondary responsibility only to the second group. For example, blood counts are always done by medical technologists, when and where they are available. Physician's assistants are taught to do blood counts but they would not do them except while learning as students, or when working in a physician's office or other situations where medical technologists were not available.

3. That students expect to receive an education which is complete in the aspects of health care in which they will be assisting, and that the level of instruction needs to be commensurate with their needs as graduates.

4. That providing adequately trained physician's assistants to overworked physicians is a practical method of helping preserve that part of medical practice known as the "art of medicine". It will give physicians more time to talk with patients and perhaps rekindle some of the warmth between them.

5. That it is necessary to find a way for students in the physician's assistant program who demonstrate superior qualifications to be admitted to medical school without a time penalty of more than a year.

6. That a deeply interested accredited university or college, with an accredited teaching hospital on the campus or in close proximity to it, is as necessary for the development and conduct of this program as it is for that of the other allied health programs. Cooperating institutions must have faculties and trustee boards with an innovative spirit.

7. That adequate outside funding for the first few years is highly desirable, if not absolutely essential.

8. That a degree program, with an adequate amount of liberal studies, is as necessary as is the professional portion of the curriculum, if the physician's assistant is to be of maximal service.

Conclusions

I am convinced that we are working on an essential requirement for a superior type of clinical medical practice. In the past, physicians have had preceptees and graduate nurses to help them. The medical school faculty has had, and continues to have, interns and residents. But most physicians now must seek help by training their own aides, or by relying on ones with previous experience, or by seeking out those trained by a proprietary school.

This movement is an attempt to furnish the internist, the generalist, and the surgeon with the well-trained assistants that they need so badly. The program also aims to give the basic education necessary for a student to take additional work to become a specialist's assistant if he cares to do so. It is an attempt to capture, nurture, and hold the idealism of youth and direct the energies of a few of them toward helping us care for the sick. If we succeed in taking bright minds and starting them on a search for excellence in this new field and, if we keep them on the right path, then I think our efforts will have been amply rewarded.

REFERENCES

1. Stead, E. A.: Conserving Costly Talents—Providing Physicians New Assistants. *JAMA* **198:**1108, 1966.
2. Rosinski, E. F. and Spencer, F. J.: The Training and Duties of the Medical Auxiliary Known as the Assistant Medical Officer. *Amer Public Health* **57-9:**1663-1669, 1967.
3. Pondy, L. R.: Personal Communication, 1970.
4. Coye, R. D., and Hansen, M. F.: The Doctor's Assistant. *JAMA* **209:**529-533, 1969.
5. Dyer, N. H.: Personal Communication, 1970.
6. Derbyshire, R. C.: Medical Licensure and Discipline in the United States. Baltimore and London: The Johns Hopkins Press, 1969, p. 107.

J. M. T. Finney Fund Lecture

Pulmonary Embolism — Its Cause and Prevention

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The partially occluded vena cava seems to be associated with fewer leg sequelae than is the total occlusion of the inferior vena cava. Partial occlusion is preferable to total ligation, except in those patients with small septic emboli which demand ligation, particularly of the ovarian veins and probably of the vena cava as well. The incidental application of a partially occluding clip, in the thrombosis-prone patient, during laparotomy for other conditions is an important concept. This concept may ultimately outweigh in importance the present philosophy of considering surgical interruption of the inferior vena cava only after pulmonary embolism has occurred.

About one out of 100 operations will be associated with some form of intravenous thrombosis in the postoperative period. Considering only major operations, the incidence rises to five or six out of 100. Of those who develop venous thrombosis, 5% to 10% will develop a pulmonary embolus; one third of this number will die.

Predisposing factors are primarily venous stasis, abnormal vein walls, and hypercoagulability of the blood, Virchow's Triad. We can do some things to help prevent the occurrence of venous thrombosis. We can specifically try to accelerate the blood flow, particularly in the lower extremities, by compression with elastic leg bandages, exercises in bed, and early ambulation.

If we are really worried about a patient, we should start the elastic support prior to the time of surgery, since many of the later episodes of venous stasis have their origin during surgery. We can also avoid those things, particularly in the postoperative period, which are known to slow up circulation. Abdominal distention may be prevented by appropriate nasogastric suction. Excessive degrees of dehydration should be avoided, as should certain positions, such as the jackknife position which promotes venous stasis.

The diagnosis of venous thrombosis is first made usually after the occurrence of a pulmonary embolus, manifested by the typical chest pain, cyanosis, dyspnea, and tachycardia. Initial X-rays are likely to be perfectly normal, and only days later may show the characteristic signs. However, there are two ways to diagnose an embolus with certainty. One is by autopsy, and the other is by pulmonary arteriography. Other tests leave much to be desired in accuracy. Scans are valuable but show false positives.

When a patient has venous thrombosis manifested by a pulmonary embolus, treatment is urgently indicated. There is little disagreement that in almost all patients, the best treatment is immediate anticoagulation by heparin. There is some question as to dextran and its effectiveness. However, sodium warfarin (*Coumadin*) and bishydroxycoumarin (*Dicumarol*) are not considered acceptable for early treatment. There are certain patients, though, who require the interruption of the vein.

These patients would be comprised primarily of those in whom anticoagulants are contraindicated strongly; those in whom anticoagulants are being used but have been unsuccessful, since another embolus has occurred even though they are on full heparinization; and those in whom a pulmonary embolus develops even while they are apparently healthy and normally ambulatory.

If we are to interrupt the vein to prevent another pulmonary embolus, there is agreement that this is preferably done at the level of the inferior vena cava. The question then arises as to the best method of interrupting the inferior vena cava. The method which has been used the longest, and with which there has been the greatest amount of experience, is ligation of the inferior vena cava. There are certain difficulties, however, associated with total occlusion of the vena cava, which we would like to avoid, without sacrificing effectiveness in preventing embolism.

As reported by a Dr. Dale in a series of ten patients, in whom he measured the venous pressure response to ligation, there is an immediate appreciable rise which falls rapidly and is only slightly increased after the first few hours. Also, there is a rapid development of collaterals as there must be, or else the patient would die. However, collaterals are never as physiological as the normal pathway, the vena cava.

Studies were made on a model to see whether we might narrow the cava enough to prevent the passage of a sizable embolus and yet not interfere with the blood flow. These studies indicated that within the normal physiological range of 1,000 to 2,000 cc a minute and a pressure of less than 50 mm or 5 cm of water, the vena cava could be narrowed with smooth clips with gaps of 3, 4, or 5 mm. If the gap is smaller than 3 mm, the distal pressure exceeds the physiologic range. We accepted as ideal, clips with gaps of 3, 3.5, or 4 mm, which do not significantly interfere with the blood flow and which do not allow passage of any sizable embolus.

Several methods have been developed for narrowing the vena cava: the smooth clip; the serrated clip; the interrupted sutures placed 5 mm apart through the anterior and posterior vein walls; and the intraluminal sieve, a crosshatching by plastic sutures through the vein wall.

Other methods have also been developed. Whether there is any real advantage of one particular type of partial interruption over another remains to be seen. It seems to me that there is a marked advantage in not having to penetrate the wall of the vena cava and not having anything within the lumen of the vena cava. Therefore, I prefer some device applied to the external surface of the vena cava.

When a clip is applied, or even if the cava is ligated, it is important that the patient continue as soon as feasible with anticoagulants. Nothing done to the vena cava affects the primary problem of intravenous thrombosis. Our routine, after applying the clip, is to first put the patient on dextran for a period of two to three days (one unit daily), and then, unless heparin has been contraindicated, to restart him on heparin for a period of five to six days, followed by sodium warfarin (*Coumadin*) for another two to three months.

Our experience, at this time, is limited to the 72 patients which we have observed for from 1 to 13 years. In this series of 72 patients, indications for surgery were: anticoagulants failed in 30 instances; anticoagulants were contraindicated in 6; embolus occurred while the patient was normally ambulatory in 6; and clip application was done incidental to laparotomy for other disease in 30.

The fourth indication will probably become the most important and the most commonly used one for interrupting the vena cava. In this particular series, 30 patients had the clip applied incidentally during laparotomy for other conditions. Most of these 30 had had a history of previous pulmonary embolus or previous venous disease.

The early mortality rate, 12%, was significant but unrelated in almost all instances to the application of the clip. Most deaths were due to the poor condition of the patient at the time. Of the late mortality rate, 19%, no death was related to the clip procedure or to the recurrence of embolism.

The two things which should be compared to see whether there is an advantage of partial occlusion or total occlusion are: first, their relative effectiveness in preventing recurrent emboli; and second, the undesirable sequelae from the standpoint of the lower extremities.

Recurrent pulmonary emboli occurred in five patients: one patient died of a coronary occlusion on the fifth postoperative day; another had massive venous thrombosis involving most major veins and died on the 28th day; a third had chest pain and a compatible X-ray 2½ years after the operation; the fourth had a probable embolus three years after clipping; and the fifth had a probable recurrence 21 days after clipping. Two other patients were suspected of having recurrence but had negative lung scans.

The experience of others using partially occluding mechanisms has been similar. Seven percent was the average reported recurrence of pulmonary emboli after partially occluding mechanisms. Ten percent was the average with recurrent pulmonary emboli after ligation of the vena cava. From the standpoint of effectiveness in preventing emboli, it seems reasonable to conclude that partial occlusion compares favorably with complete ligation of the vena cava.

In 94 extremities (not patients), no ill effects were observed after the operation. Forty-seven of these had been normal before the clip and 47 had been abnormal. Thirty-six extremities became worse after the clip. Twenty-four had minimal edema, six had moderate edema and only one developed ulceration. Recognizable phlebitis occurred in 11 extremities and 10 developed acute and extensive thrombosis at some time following the clipping procedure.

There was a relationship between previous phlebitis and the development of leg sequelae. There was also a relationship between the presence of occlusion (by phlebogram) of the iliac vein or cava, and subsequent difficulty from the postphlebitis syndrome. Recognizable recurrent episodes of phlebitis occurred almost exclusively in those extremities which had had phlebitis prior to clip application, without relation to proximal occlusion in the vena cava or iliac vein.

Acute massive thrombosis did not occur except in those that had developed occluded proximal veins at either the inferior vena caval or the iliac level, without relationship to the presence or absence of the pre-existing phlebitis of the extremity.

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Maryland's New Mental Hygiene Law

In response to a joint resolution of the General Assembly of Maryland, Governor J. Millard Tawes appointed a commission in 1966 to prepare substantive changes, as necessary, in the mental health laws of Maryland. Legislators, lawyers, and psychiatrists were appointed to the commission. Mr. Leon Pierson, a distinguished, practicing lawyer and former United States Attorney for the State of Maryland served as chairman.*

The recommendations of this commission form the basis for Senate Bill Number 210 which was passed by the legislature and signed by Governor Marvin Mandel. It became law July 1, 1970 and is known as the "Mental Hygiene Law". It is intended to be a modernization of the laws relating to the mentally ill and their care. It preserves the basic structure, responsibilities, and duties of the Commissioner and the Department of Mental Hygiene under the Office of the Secretary of Health and Mental Hygiene.

The major substantive changes of interest to the practicing physicians include: a program of mandatory readmission or re-certification of each patient at the end of each year of hospitalization; a requirement for the establishment of complete patient records and their confidentiality; a sweeping revision of requirements as to notification to each patient of the basis of his admission and his rights in regard to such admission.

Definitions

The law includes the following definitions:

Mental disorder is defined as mental illness or mental retardation, or any other form of behavioral or emotional illness resulting from any psychiatric or neurological disorder. It is intended to constitute the basic criterion for care and treatment, and intends to capture all of the possible variations of mental disease, defect or disability.

Mental illness is defined as any mental disorder, other than mental retardation, which so substantially impairs the mental or emotional functioning of an individual as to make it necessary or advisable for the welfare of the person so suffering or for the safety of the person or property of others, that the mentally ill person receive care and treatment. This definition is intended to be medically acceptable and yet sufficiently precise to allow for legal application. The term "mental illness" also replaces the words "insane", "insanity", lunacy", "mentally sick", "mental disease", "unsound mind", and similar words as they appear in the statutes of the State of Maryland.

Mental retardation is defined as a degree of subnormality of intellectual development, expected to be of life duration, which reduces the individual's capability to manage himself or his affairs. The term replaces "defective", "mental defective", "idiot", "feeble minded", and "moron", as they may appear in the statutes of the State of Maryland.

Facility shall mean any clinic, hospital, or other institutions, public or private, other than a Veterans Administration Hospital, which purports to or does provide treatment or other services to persons having any mental disorder.

The section dealing with the admission of patients to mental hospitals has been enlarged and is divided into voluntary and involuntary admissions.

** Other members were: Hon. Thomas M. Anderson, Jr., Hon. Paul A. Dorf, Hon. Arthur Dorman, L. Whiting Farinholt, Jr., Irene L. Hitchman, MD, Edward R. Jeunette, M. Jacqueline McCurdy, Jonas R. Rappeport, MD, Hon. Alan M. Resnick, Hon. M. A. Steinberg, and Donald C. Allen (reporter).*

Voluntary Admissions

The section on voluntary admissions provides that any facility licensed by or under the jurisdiction of the Department of Mental Hygiene may admit for the purpose of care or treatment, or both, any person over the age of 18 years who has a mental disorder which is susceptible to care and treatment and who requests admission to such facility. No person shall be admitted under this provision unless his condition is such that he is able to understand the nature of his request for admission, is able to request his release, and is capable of giving continuous assent to his retention by the facility.

The request for admission may be made by a formal or informal application. Informal voluntary admission may be accomplished simply by a verbal request for admission. The concept of "informal admission" is new. It should be used judiciously in a very small number of cases when, due to his illness, a patient is ambivalent to sign a formal request for admission indicating that he will stay at least three days.

Formal voluntary admissions have not been changed substantially. They require an application in writing on a form designated by the Department of Mental Hygiene. No person admitted on the basis of a formal request may be detained for more than three days after having given notice of his desire to leave the facility, unless his admission status has been changed to an involuntary admission.

A patient admitted voluntarily for care and treatment of alcoholism may be detained by a facility, as before, for a period not in excess of seven days after he has given notice of his desire to leave, unless his admission status has been changed.

No patient voluntarily admitted may be retained by a facility for any period in excess of one year. At the expiration of each one-year period of inpatient residence, the patient has to fill out a new application. A patient originally admitted on an informal basis must execute a formal application to be retained by the facility.

Voluntary admission of a person under the age of 18 is possible on the request of at least one parent or guardian. The person requesting such admission must be able to understand the nature of the request. The request must be formal, written, and assented to by an admitting physician at the facility. No patient admitted under this provision may be retained for more than three days after the person who asked for his admission requests his release, unless the patient's admission status has been changed. No person admitted under this provision may be retained by the facility for any period in excess of one year unless his admission status has been changed. At the expiration of each one-year period of inpatient residence, a new request must be executed by a parent or legal guardian of the patient.

Involuntary Admissions

The new section dealing with involuntary admissions provides that on the application of any person having a legitimate interest in the welfare of the patient, a facility may admit any person who (1) has a mental disorder, (2) needs inpatient medical care or treatment for the protection of himself or others, and (3) is unable or unwilling to be voluntarily admitted to the facility. No liability, either civil or criminal, shall attach to any applicant who makes the application in good faith and with reasonable grounds.

The application shall be in writing and dated on a form required by the Department, or in respect to Veterans Administration Hospitals, meets the requirements of that administration. It should contain a description of the relationship of the applicant to the patient, be signed by the applicant, and be accompanied by the certificates of two physicians indicating that the patient has a mental disorder, and for his protection or the protection of others needs inpatient care or treatment.

Physicians' Certificates

In order to execute a certificate, the physician must be licensed to practice in the State of Maryland. He must not be financially interested by reason of ownership or salary in any private facility in which it is proposed to admit the patient. He must not be related by blood or marriage to the prospective patient or applicant. No certificate shall be used for purposes of admission if based on an examination made more than 30 days prior to receipt of the application for admission.

The important substantive change of this provision is that it allows a physician on the staff of a public facility to execute a medical certificate for a patient proposed for admission to the facility.

The intent of this change is to enable the physicians at the state mental hospitals to re-certify patients on a yearly basis, and to allow for an involuntary admission of a patient under emergency conditions. The regular involuntary admission of a prospective patient will have to be accompanied by two physician's certificates, and a written request from the responsible relative or a person legitimately concerned with the patient's welfare.

Notification of Admission Status

Entirely new is the provision for notification to the patient of his admission status and rights.

The statute requires that within 12 hours after admission to a facility, every patient must be notified of his admission status and the provision of the law pertaining to his admission. This shall be done by reading to the patient the provision under which he is admitted and those provisions pertaining to his rights. A summary should be read to the patient in

clear and simple terms. In addition, the patient should be advised of his right to counsel with an attorney of his choice. If he does not have his own attorney he shall be advised of the availability of the services of the Legal Aid Bureau and Lawyer Referral Services. The patient shall be given the opportunity to call or write his attorney or the agencies specified.

The Department has prepared a form which includes the provisions of this section of the law which may be given to the patient or his relatives or friends. One copy of this form containing a certification of compliance with this section by the person in charge of admissions at the facility must be filed with each patient's record. If the patient is unable to understand the notification and its legal effect, the notification shall also be given to the patient's next of kin, or any other person deemed to have a significant interest in the patient's status. Notification shall be given again to each person at the time of the execution of the new application for admission by both voluntarily and involuntarily admitted patients.

Patient's Rights

Another provision deals with patient's rights. It provides that patients shall at all reasonable times have available writing instruments, stationery, and postage and may use this material to correspond with anyone, subject to such reasonable limitations as may be imposed by the facility. All correspondence shall be forwarded to the addressee without delay and without being opened, except under the direction of the addressee. When for medical reasons limitations are imposed, they must be made a permanent part of the record and must be signed by a physician.

Patients shall at all reasonable hours have access to telephones, and shall be permitted to call any person who has advised the facility in writing of his willingness to receive such telephone communications. When for medical or administrative reasons patients are prohibited from having telephone communications, such prohibition must be made a permanent part of the medical record and signed by a physician.

Every patient is entitled to receive visits from an attorney or clergyman of his choice at all reasonable hours.

When medically justified, a patient may be restricted from receiving visitors other than his attorney or clergyman, if such restriction is made part of the permanent record and is signed by a physician. Refusal of patients to see visitors must also be made permanent parts of their record.

No patient in any facility shall be deprived of his right to vote, receive, hold, or dispose of property unless he has been declared to be incompetent by a court.

Any person who knowingly interferes with the right of a patient in a facility is guilty of a misdemeanor and upon conviction shall be imprisoned for a period not to exceed two years or fined an amount not to exceed $5,000, or both.

Habeas Corpus

At any time, any person admitted to any facility or Veterans Administration Hospital, or anyone in his behalf, may apply to any appropriate court for a writ of habeas corpus to determine the cause and legality of his admission and continued detention.

Judicial Release

In order to obtain a judicial release, a patient or any person having a legitimate interest in his welfare may file a petition in the equity court of the county in which he resides, or resided at the time of his admission. The issues to be determined are: (1) does the patient have any mental disorder and, (2) is the disorder of such a nature that for the protection of himself or others the patient needs inpatient medical care or treatment. If either question is answered in the negative, the patient must be released from the facility. If both questions are answered affirmatively by the jury or court sitting as jury, the patient will be remanded to the facility or Veterans Administration Hospital from which he petitioned his release.

Mental Disorder as a Defense in Criminal Cases

New provisions dealing with pleas of insanity in criminal cases were enacted by the General Assembly in its 1967 session and have not been changed by the commission.

Appointment of Superintendents

Another substantive change provides that the superintendents of state facilities shall be appointed by the Secretary of Health and Mental Hygiene with the advice of the Commissioner, and shall have such qualifications as may be specified by the Secretary. It eliminates the previous requirements that superintendents of mental retardation facilities have to be experienced physicians, and that superintendents of mental hospitals have to be qualified psychiatrists.

The implementation of the new mental hygiene law places a considerable burden on the hospital administration and the medical staff. However, in the long run, it should lead to improvement in patient care.

The members of the commission believed that provisions detailing the civil rights of patients strike a meaningful balance between their rights, the rights of the public to be protected from dangerously mentally ill persons, and the reasonable care and treatment of persons who suffer from mental illness.

your medical faculty at work

by John Sargeant
Executive Director

The Executive Committee met on Thursday, August 6, 1970, and took the following actions:

1. Endorsed, in principle, the following studies that had requested Faculty approval:
   a. Study conducted by Catholic University of America in Washington, D. C., on Differentials in Health Care of the Sensory Deprived
   b. Study and Evaluation of Clinical Laboratory Tests Performed in Physicians' Offices, conducted by William B. Hope, Jr., of The Johns Hopkins School of Hygiene and Public Health
   c. Study of mongolism in Negroes, to be conducted under the auspices of the University of Maryland Hospital
   d. Drug Abuse Treatment Program at Sinai Hospital, which conforms with Faculty guidelines;
2. Agreed to refer to the Maryland Ear, Nose and Throat Society a proposal for a list of those ENT specialists who perform audiometric tests, and an evaluation of the quality of such testing;
3. Declined to review the current system of physician referral provided to members of the public;
4. Approved recommendations for possible appointment of the following physicians to the Medical Advisory Board of the Department of Motor Vehicles:
   William R. Campbell, MD, Salisbury, orthopedist
   Marcus D. Stephanides, MD, Salisbury, orthopedist
   John T. Bulkeley, MD, Salisbury, internist
   William C. Weintraub, MD, Greenbelt, general practitioner
   Paul V. Joliet, MD, Hagerstown, public health
5. Declined to regularly participate in the funding of the MEDIHC program (Military Experience Directed Into Health Careers) through the Maryland Hospital Education and Research Foundation. The program trains discharged or retired military persons for careers in the civilian health field. The committee expressed continuing interest in this program and suggested other means of funding;
6. Regretted its inability to financially assist the founding of Epoch House, a proposed Youth Drug Abuse Rehabilitation Center, even though it recognized the project as worthwhile;
7. Approved computerization of Faculty membership records and expenditure of appropriate funds;
8. Authorized its annual sustaining membership in the Maryland Public Health Association;
9. Determined to proceed with injunctive action against the use of the term "chiropractic physician" and requested an estimate of legal costs for such action;
10. Declined to establish an "Enterprise" telephone number for use throughout the state. (Such a number uses direct dialing techniques, and the long distance charge is billed to the receiving number—in this case, the Faculty);
11. Authorized employment and expenditure of funds for an Actuarial Consultant to analyze the current Professional Liability program and to make any applicable recommendations;
12. Expressed appreciation to the Subcommittee on Maternal Welfare which is currently developing guidelines for therapeutic abortions in the event that Maryland's statute is declared unconstitutional;
13. Approved the nurse-midwife protocol as recommended by the Nurse Liaison Subcommittee;
14. Approved May 12, 13, and 14 as the 1971 Annual Meeting dates, and the location of the meeting as the Civic Center;

15. Approved holding a proposed Symposium on Emergency Room Medical Care, with lunch provided, at St. Joseph Hospital;
16. Authorized the President, President-elect, and Council Chairman to meet with the Editorial Board of the *News American* if such a meeting is arranged;
17. Heard that the Executive Director had been interviewed by representatives of "Nader's Raiders" to discuss peer review, utilization review, and self-discipline;
18. Approved a recommendation of the Nursing Home Liaison Subcommittee to have the Faculty provide consultants to review the cases of those Medicaid patients who have requested a fair hearing concerning the decision made by the Department of Health and Mental Hygiene that they need a lower level of care;
19. Approved a recommendation from the same subcommittee to solicit Faculty volunteers as consultants;
20. Approved a proposal of the Board of Medical Examiners that the Faculty president give "words of welcome" at the biannual medical examinations;
21. Adopted a policy that personnel matters such as employees' salaries and other similar confidential information should not be revealed without written request for and approval from the Executive Committee.

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Baltimore City health department

Health Services for Summer Programs

Head Start and Early School Admissions

The City Health Department was active in a number of summer child health programs. For the fifth consecutive year the department administered the health services for the Head Start and Early Admissions programs. Established to aid disadvantaged four and five year olds make better adjustments to school situations, these two programs together served about 800 children.

The City Health Department commitment included a complete physical examination including a neurological evaluation, a dental check-up, tuberculin skin test, urinalysis, a blood test for anemia, and necessary immunizations. Where indicated, parents were counseled for the correction of defects and contacted for follow-up checks on corrections.

These services were arranged for and supervised by John B. Saratsiotis, MD, director of the City Health Department's Bureau of School Hygiene, with the assistance of the Bureaus of Public Health Nursing and Dental Care, local physicians and dentists, the comprehensive medical programs, and other concerned City Health Department bureaus. Funding was provided by federal funds through the City Community Action Agency, Model Cities Agency, and the departments of education and health.

Summer Youth and Educational Enrichment Programs

In the Summer Youth Program, sponsored by the Community Action Agency for the third summer, the City Health Department provided physical examinations and follow-up for 2,600 children, 8 to 15 years old. Examinations were conducted at CAA neighborhood centers.

The department also provided medical evaluations for 1,720 children attending junior high school this fall. These children participated in a summer educational enrichment program. An additional 540 school children were evaluated before participating in summer school swimming lessons conducted by the Division of Physical Education of the city schools.

Mental Health at Camp Jolly Acres

In a new program started June 22, 1970, 60 children with identified behavior problems, ranging from mild to severe, were enrolled at Camp Jolly Acres, Whitehall, Maryland, for up to 24 days. This project was made possible by funds secured under the National Elementary and Secondary Education Act and the joint efforts of the City Health Department's Mental Hygiene Clinics and the City Department of Education. The camp facilities were made available by the Lutheran Social Services of Maryland.

Unlike other camp projects for youth of this type, which are run exclusively for them and often as day camps, the 60 youngsters chosen for this experience lived, ate, and played with a group of normal children. Two city school teachers were present to aid in improving communication skills, including reading ability. Five mental health counselors, under the guidance of Marvin C. Jones, director of the Eastern and Southeastern Mental Hygiene Clinics, were available around the clock to assist the 60 campers and their parents. Total cost for this program was $15,-142.

Hyperactive Children at Black Rock Camp

A second new specialized summer program for youngsters was developed by James D. Chan, Consultant in Physical Therapy in the Department's Comprehensive Children and Youth Programs. Mr. Chan was instrumental in obtaining funds from federal and local sources for 40 hyperactive inner-city children, currently on medication, to attend Black Rock YMCA Country Day Camp at Butler, Maryland.

Identified and selected by The Johns Hopkins Hospital Department of Pediatric Psychiatry and the Diagnostic and Evaluation Clinic, the children had a two-week supervised experience which focused on reading proficiency, writing skills, and improved motor coordination. Total cost of this program was $9,000.

Camp Concern

For the third consecutive year, the City Health Department staff was involved in the Department of Recreation's Camp Concern Program held at the Naval Training Center, Bainbridge, Maryland, for 5,000 disadvantaged youngsters.

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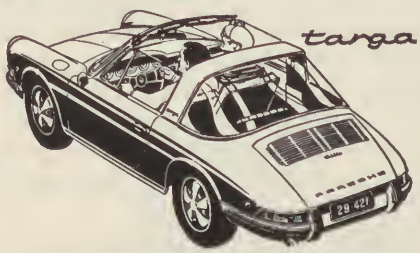
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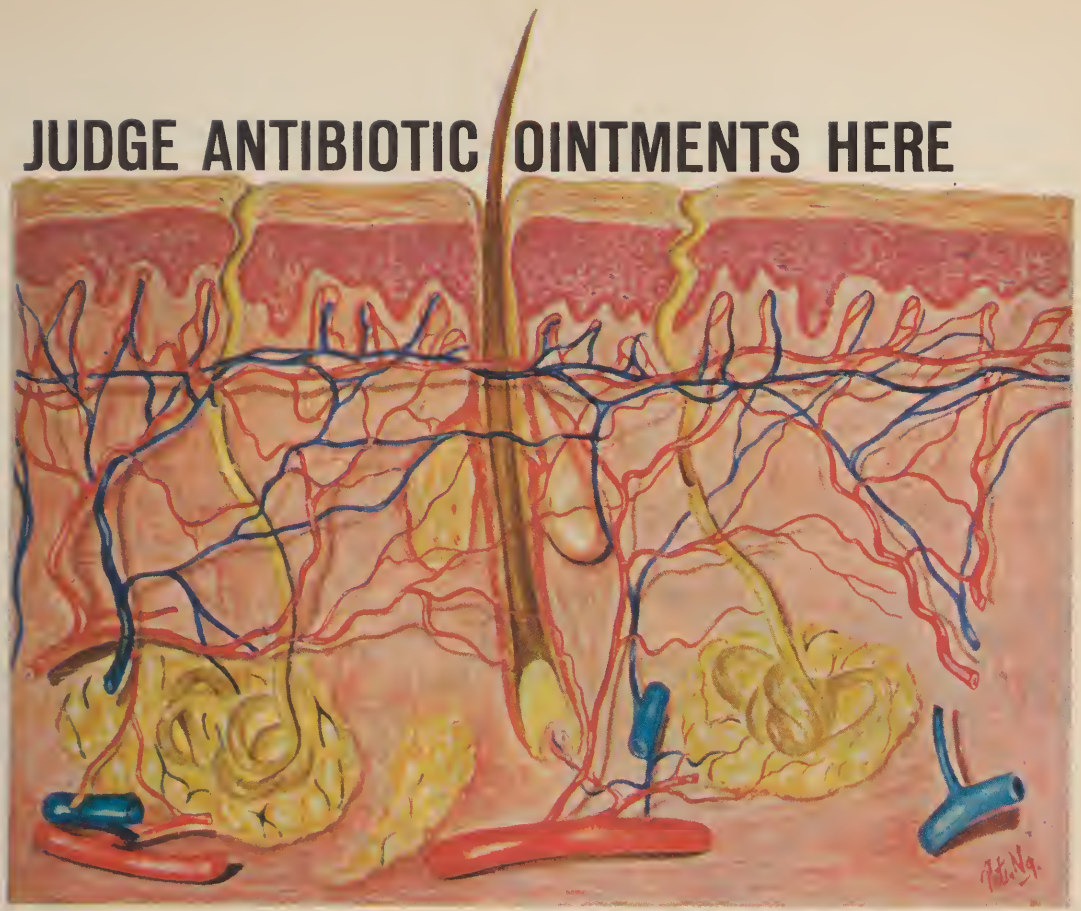
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NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

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Recent and Upcoming Library Meetings

The regional meeting of the Washington Area Group of the Medical Library Association, comprised of Virginia, Maryland, Washington, D.C., and newly-acquired North Carolina, will meet in Baltimore at the Health Sciences Library on Saturday, October 24, 1970.

While use of audio-visual media in the library will be stressed, there will be something of interest offered to all types of medical librarians. This program is being jointly sponsored by the Medical and Chirurgical Faculty Library and the Health Sciences Library.

Norman L. Stearns, MD, the Executive Director at the Postgraduate Medical Institute in Boston, will be the afternoon guest speaker.

* * *

The 61st Special Libraries Association annual meeting was held June 7-11, 1970 in Detroit. The keynote phrase of the conference was "The Changing Focus of Special Libraries".

Over 1,400 registrants attended the meetings in Cobo Hall, the immense new convention arena.

Program topics ranged from, "What Will Change? What Must Change"? to "The Peter Principle, Why Things Always Go Wrong", by Dr. Lawrence J. Peter.

NEW ACCESSIONS—BOOKS
(Arranged by Author and Title)

American Association of Blood Banks.
Manual of blood component preparation. Chicago, 1969.

American Association of Blood Banks.
Physician's handbook of blood component therapy. Chicago, 1969.

American Association of Blood Banks.
A seminar on compatibility testing presented at the 21st annual meeting of the American Association of Blood Banks, Washington, Oct. 28, 1968. Chicago, 1968.

American Association of Blood Banks. Committee on Standards.
Standards for blood banks and transfusion services. 5th ed. Chicago, 1970.

American Humane Association. Children's Division.
Child protective services and the law. Denver, Colorado, 1967.

American Humane Association. Children's Division.
Child victims of incest. Reported by Yvonne M. Tormes. Denver, Colorado, 1968.

American Medical Association.
An information booklet on the American Medical Association; guardian of the nation's health since 1847. Chicago, 1970.

American Medical Association.
Medical and surgical motion pictures, a catalog of selected films. 2d rev. ed. Chicago, 1969.

American Medical Association. Committee on Transfusion and Transplantation.
General principles of blood transfusion. Chicago, 1970.

American Medical Association, Department of Allied Medical Professions and Services.
Directory of accredited allied medical educational programs, 1969-70. Chicago, 1969- .

American Medical Association, Department of Mental Health.
Bibliography on drug abuse and drug dependence. Chicago, 1970.

American Society for Artificial Internal Organs.
Transaction, v. 14- 1968- . Washington, Georgetown University Hospital, 1968- . Editor: G. E. Schreiner.

American Society of Clinical Oncology. Education Committee.
A listing of cancer training and teaching programs for members of the American Society of Clinical Oncology. Prepared by the Education Committee, Kenneth B. Olson, chairman. Washington, U.S. National Cancer Institute, 1969.

Annual progress in child psychiatry and child development, 1968- . Editors: S. Chess & A. Thomas. New York, Brunner/Mazel, 1968- .

Association of Hospital and Institution Libraries. Hospital Library Standards Committee.
Standards for library services in health care institutions. Chicago, American Library Association, 1970.

Baltimore City Health Department.
Report of a Committee to Study Space Heaters. John B. DeHoff, chairman. Baltimore, 1970.

Baron, Denis N.
Recent advances in medicine. 15th ed. London, Churchill, 1968.

Benda, Clemens E.
Down's syndrome; mongolism and its management. rev. ed. New York, Grune & Stratton, 1969.

Bennett, Margaret.
The peripatetic diabetic. New York, Hawthorn Books, 1969.

Bennett, Peter B.
The physiology and medicine of diving and compressed air work. Baltimore, Williams & Wilkins, 1969.

Bethlem, J.
Muscle pathology; introduction and atlas. New York, American Elsevier, 1970.

Bing, Elisabeth D.
The adventure of birth; experiences in the Lamaze method of prepared childbirth. New York, Simon & Schuster, 1970.

Botsford, Thomas W.
The acute abdomen. Philadelphia, Saunders, 1969.

Brewer, Earl J.
Juvenile rheumatoid arthritis. Philadelphia, Saunders, 1970.

Brown, William J.
Syphilis and other venereal diseases. Cambridge, Harvard University Press, 1970.

Browning, Ethel C.
Toxicity of industrial metals. 2d ed. New York, Appleton-Century-Crofts, 1969.

Bücherl, Wolfgang.
Venomous animals and their venoms. New York, Academic Press, 1968- .

Burston, Geoffrey R.
Self-poisoning. London, Lloyd-Luke, 1970.

Campbell, George, D.
Oral hypoglycaemic agents; pharmacology and therapeutics. London, Academic Press, 1969.

Carroll, Charles R.
Alcohol; use, nonuse, and abuse. Dubuque, Iowa, Brown, 1970.

Carter, Richard L.
Infectious mononucleosis. Oxford, Blackwell, 1969.

Clark, Alfred W.
Fraser House; theory, practice, and evaluation of a therapeutic community. New York, Springer, 1969.

Conferences in pediatric urology. Edited by Edward C. Muecke and Victor F. Marshall. Baltimore, Williams & Wilkins, 1969.

Cruzat, Gwendolyn S.
Relationships of biomedical information services; final report. Detroit, 1969.

Current pediatric therapy. v. 4- , 1970- . Philadelphia, Saunders.

Curry, Alan S.
Poison detection in human organs. 2d ed. Springfield, Ill., Thomas, 1969.

Curry, George J.
Profiles in trauma. Springfield, Ill., Thomas, 1969.

Deichmann, William B.
Toxicology of drugs and chemicals. 4th ed. New York, Academic Press, 1969.

Duke-Elder, Sir William S.
The practice of refraction. 8th ed. St. Louis, Mosby, 1969.

Easson, William M.
The severely disturbed adolescent; inpatient, residential and hospital treatment. New York, International Universities Press, 1969.

Emerling, Carol G.
The allergy cookbook; delicious recipes for every day and special occasions. Garden City, Doubleday, 1969.

Ferreira, Antonio J.
Prenatal environment. Springfield, Ill., Thomas, 1969.

Finch, Stuart M.
Psychiatry for the pediatrician. New York, Norton, 1970.

Finnie, Nancie R.
Handling the young cerebral palsied child at home. New York, Dutton, 1970.

Flandorf, Vera S.
Books to help children adjust to a hospital situation. Chicago, American Library Association, 1967.

Flint, Thomas.
Emergency treatment and management. 4th ed. Philadelphia, Saunders, 1970.

Fort, Joel.
The pleasure seekers; the drug crisis, youth, and society. Indianapolis, Bobbs-Merrill, 1969.

Fuchs, Walther A.
Lymphography in cancer. New York, Springer-Verlag, 1969.

Furfey, Paul H.
Interaction of deaf and hearing in Baltimore city, Maryland. Washington, Catholic University of America, 1968.

Gamage, James R.
A comprehensive guide to the English-language literature on cannabis (marihuana). Beloit, Wisconsin, STASH Press, 1969.

Garb, Solomon.
Disaster handbook. 2d ed. New York, Springer, 1969.

Glaser, William A.
Paying the doctor; systems of remuneration and their effects. Baltimore, Johns Hopkins Press, 1970.

Gross, Robert B.
An atlas of children's surgery. Philadelphia, Saunders, 1970.

Haj, Fareed.
Disability in antiquity. New York, Philosophical Library, 1970.

Harris, William H.
Skeletal renewal and metabolic bone disease. Boston, Little, Brown, 1970.

Hartman, Ernest.
Sleep and dreaming. Boston, Little, Brown, 1970.

Hayhoe, F. G. J.
An atlas of haematological cytology. New York, Wiley, 1970.

Helt, Eric H.
Coronary care units in small hospitals; the Standish (Michigan) experience. Battle Creek, Mich., Kellogg Foundation, 1970.

Hoffman, William S.
The biochemistry of clinical medicine. 4th ed. Chicago, Year Book Medical Pub., 1970.

Hood, Raleigh M.
Management of thoracic injuries. Springfield, Ill., Thomas, 1969.

Hubble, Douglas.
Paediatric endocrinology. Philadelphia, Davis, 1969.

Hunter, Donald.
The diseases of occupations. 4th ed. Boston, Little, Brown, 1969.

Inhalation carcinogenesis; proceedings of a biology division, Oak Ridge National Laboratory Conference held in Gatlinburg, Tenn., Oct. 8-11, 1969. Editor: M. G. Hanna. Springfield, Va., U.S. Clearinghouse for Federal, Scientific and Technical Information, 1969.

International Conference on Congenital Malformations. 3d. Hague, 1969.
Abstracts of papers presented. Amsterdam, Excerpta Medica Foundation, 1969.

International Congress of Plastic and Reconstructive Surgery. 4th, Rome, 1967.
Transactions; quadrennial meeting of the International Confederation for Plastic and Reconstructive Surgery. Amsterdam, Excerpta Medica Foundation, 1969.

International Congress of Ultrasonography in Ophthalmology. 4th, Philadelphia, 1968.
Ophthalmalic ultrasound; proceedings. St. Louis, Mosby, 1969.

International Symposium on Questions of Cerebral Circulation. 3d, Salzburg, 1966.
Research on the cerebral circulation. Springfield, Ill., Thomas, 1969.

Jenkins, Leonard C.
General anesthesia and the central nervous system; a basic science and clinical consideration. Baltimore, Williams & Wilkins, 1969.

Johns Hopkins University. Welch Medical Library.
Journals currently received by the libraries of the Johns Hopkins Medical Institutions, 1970- . Baltimore, 1970- .

Johnson, Harold D.
The cardia and hiatus hernia. Springfield, Ill., Thomas, 1968.

Jopling, W. H.
The treatment of tropical diseases. Bristol, Wright, 1968.

Karczmar, Alexander G.
Neurophysiological and behavioral aspects of psychotropic drugs. Springfield, Ill., Thomas, 1969.

Kasdon, David L.
International family planning, 1966-1968, a bibliography. Chevy Chase, Md. U.S. National Institute of Mental Health, 1969.

Kline, Nathan S.
Depression; its diagnosis and treatment. Lithium; the history of its use in psychiatry. New York, Brunner Mazel, 1969.

Lain Entralgo, Pedro.
Doctor and patient. New York, McGraw-Hill, 1969.

Laufe, Leonard E.
Obstetric forceps. New York, Hoeber, 1968.

Loebs, Stephen F.
The Traverse City affiliation in extended care. Ann Arbor, Bureau of Hospital Administration, University of Michigan, 1969.

Louisell, David W.
Medical malpractice. By David W. Louisell and Harold Williams. New York, Bender, 1969.

Mammography; symposium given on August 24, 1968 at University of California School of Medicine, San Francisco, Calif. Edited by H. J. Burhenne, J. E. Youker and R. H. Gold. Basel, Karger, 1969.

Maryland. Laws, statutes, etc.
Law regulating the practice of medicine in Maryland; annotated code of the public general laws of Maryland (1957 edition and 1970 supplement). Title "Health", article 43, section 119-136A, inclusive. Annapolis, 1970.

Maryland. State Board of Physical Therapy Examiners.
Directory of licensed physical therapists, April 1, 1970- . Baltimore, 1970- .

Maryland. State Dept. of Health. Division of Medical Facilities Development.
Licensed institutions: nursing homes-extended care, intermediate care facilities—type A (long term care), intermediate care facilities—type B (personal care, domiciliary care homes, residential treatment centers for emotionally disturbed children and adolescents). Baltimore, 1970.

Medical and surgical cardiology. By William Cleland and others. Oxford, Blackwell, 1969.

Medical economics.
Now you can incorporate! Oradell, N.J., Medical Economics Book Div., Inc., 1969.

Medical Library Association.
Handbook of medical library practice. 3d ed. Gertrude L. Annan and Jacqueline W. Felter, editors. Chicago, 1970.

Miller, Genevieve, ed.
Bibliography of the history of medicine of the United States and Canada, 1939-1960. Baltimore, Johns Hopkins Press, 1964.

Modern drug encyclopedia and therapeutic index; a compendium. 11th ed. New York, Donnelley, 1970- . Editor: A. J. Lewis.

Mosher, Loren R.
Special report on schizophrenia. By Loren R. Mosher, and David Feinsilver and others. Chevy Chase, U.S. Dept. of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, National Institute of Mental Health, 1970.

Moritz, Alan R.
Handbook of legal medicine by Alan R. Moritz and R. Crawford Morris. 3d ed. St. Louis, Mosby, 1970.

Nagi, Saad Z.
Disability and rehabilitation; legal, clinical, and self-concepts and measurement. Columbus, Ohio State University Press, 1969.

National Research Council. Committee on Brain Sciences.
IBRO survey of research facilities and man-power in brain science in the United States. Washington, National Academy of Sciences, 1969.

Nobel Symposium. 10th, Stockholm, 1968.
Disorders of the skull base region. Edited by Carl-Axel Hamberger and Jan Wersäll. New York, Wiley Interscience Division, 1969.

Obstetrics illustrated by M. M. Garrey and others. Baltimore, Williams and Wilkins, 1969.

Peltz, Edith M.
Bland but grand; a cookbook for people on certain continuing diets, by Edith M. Peltz, in cooperation with the Women's Auxiliary of the Gastro-Intestinal Research Foundation. 1st ed. Garden City, N.Y., Doubleday, 1969.

Penning, L.
Functional pathology of the cervical spine. Amsterdam, Excerpta Medica Foundation, 1968.

Physician's management
Office procedure manual for the medical assistant. Evanston, Ill., Harbrace Pub., 1968.

The Physiopathogenesis of the epilepsies.
Edited by Henri Gastaut and others. Springfield, Ill., Thomas, 1969.

Quick, Armand J.
Bleeding problems in clinical medicine. Philadelphia, Saunders, 1970.

Randall, Charles H.
Medicolegal problems in blood transfusions. Chicago, American Association of Blood Banks, 1969.

Raush, Harold L.
The halfway house movement. By Harold L. Raush with Charlotte L. Raush. New York, Appleton-Century-Crofts, 1968.

Regional medical programs, a progress report.
Chicago, American Hospital Association, 1968.

Ruge, Daniel.
Spinal cord injuries. Edited by Daniel Ruge. Springfield, Ill., Thomas, 1969.

Sarno, John E.
Stroke. By John E. Sarno and Martha T. Sarno. New York, McGraw-Hill, 1969.

Scheie, Harold G.
Adler's Textbook of ophthalmology. 8th ed. by Harold G. Scheie and Daniel M. Albert. Philadelphia, Saunders, 1969.

Schleg, Marilyn C.
The use of hospital health science libraries. By Marilyn C. Schleg and Vern M. Pings. Detroit, Wayne State University, 1969.

Scott, Donald F.
About epilepsy. New York, International Universities Press, 1969.

Sigrell, Bo.
Group psychotherapy. Stockholm, Almquist & Wiksell, 1968.

Sklansky, Morris A.
The high school adolescent. By Morris A. Sklansky, Sylvia W. Silverman and Helen G. Ravichow. New York, Association Press, 1969.

Smith, David W.
Recognizable patterns of human malformation. Philadelphia, Saunders, 1970.

Smith, Gloria L.
Library use of computers. Edited by Gloria L. Smith and Robert S. Meyer. New York, Special Libraries Association, 1969.

Social, Educational Research and Development, Inc.
Institutional library services. Study authorized by Paul Powell, state librarian. Chicago, American Library Association, 1970.

Stark, Richard B.
Cleft palate. Edited by Richard B. Stark. New York, Hoeber, 1968.

Strauss, Alfred A.
Immunologic resistance to carcinoma produced by electrocoagulation. Springfield, Ill., Thomas, 1969.

Swaiman, Kenneth F.
Neuromuscular diseases of infancy and childhood. By Kenneth F. Swaiman and Francis S. Wright. Springfield, Ill., Thomas, 1970.

Symposium on Alcohol Metabolism, Detroit, 1968.
Biochemical and clinical aspects of alcohol metabolism. Edited by Vishwanath M. Sardesai. Springfield, Ill., Thomas, 1969.

Taylor, Kent.
Computer applications in psychotherapy. Chevy Chase, Md., U.S. National Institute of Mental Health, 1970.

Thyroid cancer. Edited by Chr. E. Hedinger. Berlin (etc.) Springer-Verlag, 1969.

Trigeminal neuralgia. Edited by Rolf Hassler and A. Earl Walker. Stuttgart, Thieme; Philadelphia, Saunders, 1970.

U.S. Army Medical Service.
Medical supply in World War II. Prepared and published under the direction of Leonard D. Heaton. Editor in chief: Robert S. Anderson. Editor: Charles Wiltse. Washington, Office of the Surgeon General, Dept. of the Army, 1968.

U.S. Food and Drug Administration. Science Information Facility.
National drug code directory, June 1970. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, 1970.

U.S. National Center for Health Statistics.
State licensing of health occupations. Washington, For sale by the Supt. of Docs., U.S. Govt. Print. Off., 1968.

U.S. National Clearinghouse for Drug Abuse Information.
Answers to the most frequently asked questions about drug abuse. Chevy Chase, 1970.

U.S. Naval flight surgeon's manual. Washington, For sale by the Supt. of Docs., U.S. Govt. Print. Off. 1968. Prepared by Biotechnology, Inc., Arlington, Va. under contract with Physiological Psychology Branch, Psychological Sciences Division, Office of Naval Research.

U.S. Public Health Service. Kidney Disease Program Analysis Group.
Kidney disease. A report to the Surgeon General. Benjamin T. Burton, chairman. Washington, 1967. (U.S. Public Health Service Publication No. 1745).

Vascular insufficiency. Edited by John R. Kelsey, Jr. and Earl F. Beard. Springfield, Ill., Thomas 1969.

Vollman, Rudolf F.
Down's syndrome (mongolism). Bethesda, U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Institutes of Health, 1969.

Von Hippel, Arndt.
Chest tubes and chest bottles. Springfield, Ill., Thomas, 1970.

Wahl, Norman.
Oral signs and symptoms. Springfield, Ill., Thomas, 1969.

Walton, John N.
Disorders of voluntary muscle. 2d ed. Boston, Little, Brown, 1969.

Weed, Lawrence L.
Medical records, medical education, and patient care. Cleveland, Press of Case Western Reserve University; distributed by Year Book Medical Pub., 1970.

Western Conference on Anesthesiology. 10th, San Diego, 1967.
Pharmacology of anesthetic agents and their measurements. Edited by Verne L. Brechner and Carter M. Ballinger. Salt Lake City, University of Utah Press, 1969.



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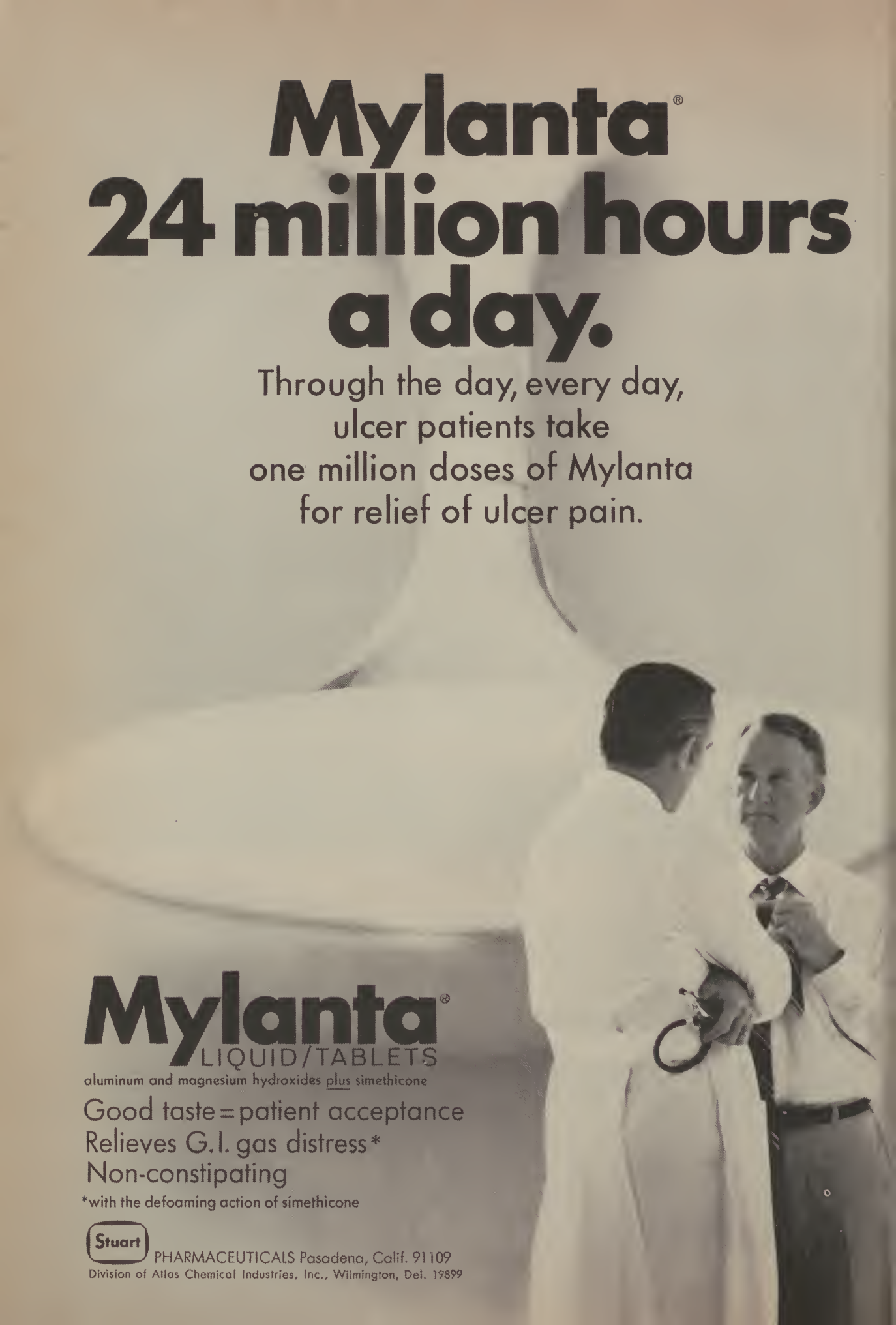
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Ritual Execution

Despite abolition of the death penalty, several innocent persons are executed in Hawaii each year. The site of these executions is rather rigidly delineated, being immediately adjacent to a body of water such as a beach, stream, or swimming pool. The victim dives into the water, hits his head against the bottom, sustains a cervical fracture, and floats unconscious to the surface. Well-meaning onlookers rush to the rescue, quickly dragging and carrying him from a watery grave. Unfortunately, they almost invariably forget to support his head, which, acutely hyperextended and rolling from side to side, effectively transects the spinal cord.

Paradoxically, the unfortunate victim is safest while floating in the water, which acts as a total body splint and effectively prevents excessive movements of the head on the trunk. Ideally, after insuring an adequate airway, he should be left in the water until a rigid body support (a surfboard is ideal) can be obtained and slid under the body. He can then be lifted in toto from the water and transported, still lying on the board, to the hospital.

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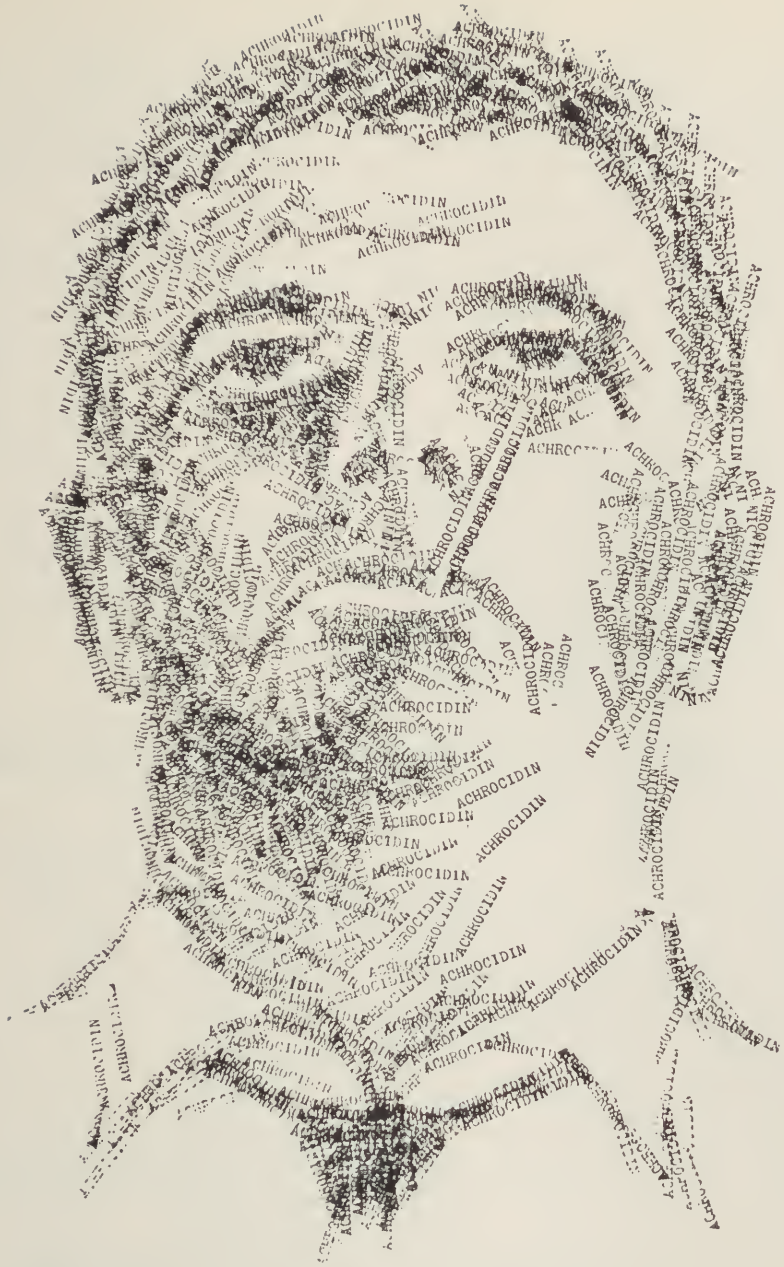
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ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

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Drug Effects on Hearts

Two classes of calm-down and pep-up drugs apparently cause heart damage if large doses are consumed over long periods of time, a heart specialist reports. Dr. Carl S. Alexander of Minneapolis tells of finding disturbed heart rhythm, enlargement of the heart, and heart attacks in eight persons who had taken drugs in the phenothiazine tranquilizer family and the imipramine family of antidepressants, or psychic energizers.

Pollution and the Common Cold

City dwellers would have fewer attacks of the common cold—perhaps 10% to 20% less—if polluted air were cleaned up, indicates a three-year study in New York city of colds, weather factors, and air pollution. The research project was conducted by four scientists from the University of Washington School of Medicine, Seattle.

AMA Judicial Council: Treatment of a Family Member

The Judicial Council of the American Medical Association recently issued the following statement regarding the provision of medical care to members of a physician's family: "From time immemorial it has been considered unwise and improper for a physician to treat members of his immediate family for other than minor health problems or in emergencies. For him to do so would be in violation of Section 6 of the Principles of Medical Ethics and therefore unethical.

"Even if for some good reason it becomes necessary to treat a member of his immediate family, a physician should not charge, or make a claim for, or receive compensation for such service from the patient or from a third-party payor on the patient's behalf."

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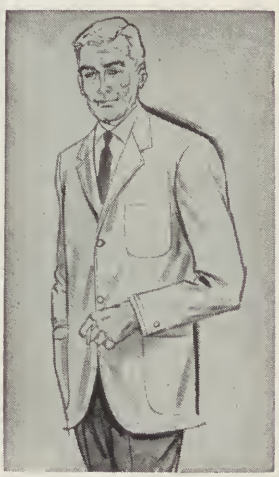
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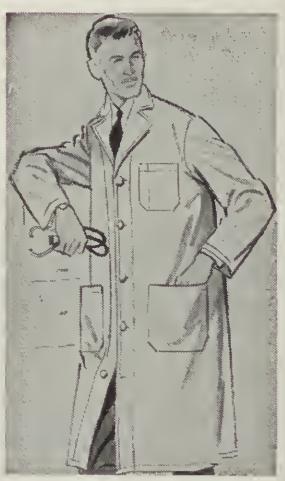
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Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenamena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastraintestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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Maryland State department of health and mental hygiene

Fact Sheet For the 1970 Fiscal Year

In 1970, Maryland's hospitals for the mentally ill again treated a record number of patients, reflecting primarily the continuing rise in admissions of alcoholics. Ten years ago these facilities treated 16,268 patients; by 1970, this had increased 59.3%—to 25,919. However, due to shortened periods of hospitalization of new admissions and the gradual, continuing decrease in the number of long-term patients, the average daily size of the patient population declined 17.0% during this period from 8,576 to 7,114.

FISCAL YEAR	AVERAGE SIZE OF PATIENT POPULATION	TOTAL NUMBER TREATED DURING YEAR	ADMISSIONS	TOTAL SEPARATIONS
1960	8,576	16,268	4,640	4,751
1962	8,291	17,580	6,221	6,111
1964	8,035	19,424	7,871	8,104
1966	8,102	21,542	9,675	9,735
1968	7,711	23,598	11,997	12,132
1970	7,114	25,919	14,496	14,664
NET CHANGE	—1,462	+ 9,651	+ 9,856	+ 9,913
PERCENT CHANGE	—17.0	+59.3	+112.4	+108.7

A similar upward trend has been observed in virtually all private psychiatric hospitals, psychiatric units of general hospitals, clinics and other community centers reporting to Maryland's Psychiatric Case Register. For example, total admissions to the 110 clinics are estimated to have increased 12.7% from 19,220 in 1969 to 21,650 in 1970. Since other states have reported comparable data, the question is frequently posed whether or not this reflects a rising incidence of mental illness.

This cannot be readily answered since the ratio between number of individuals treated in psychiatric facilities and total number of mentally disturbed or ill is not known. However, it is generally believed that the rate of occurrence of most mental illnesses has not changed appreciably and that these expanding figures, therefore, primarily reflect the increase in multiple admissions to psychiatric hospitals and clinics for short-term intensive treatment of alcoholism and acute psychoneurotic and personality disturbances. Recent legislation and court decisions have intensified these trends.

Rosewood, the larger of Maryland's two hospitals for the mentally retarded, last year operated as much as 25.2% in excess of capacity and therefore persisted in its policy of restricting admissions to available space and staff. Although the patient population has increased from 2,254 in 1960 to the current 2,744, Maryland's ratio of 86.4 patients per 100,000 state residents is 11.7% below the national average. In an effort to resolve this chronic problem, the department is engaged in a three-pronged program involving construction of new residential retardation facilities on a regional basis, development of coordinated community-based services as alternatives to hospitalization, and removal of emotionally disturbed children from Rosewood, allowing conversion of two buildings for the care of the mentally retarded.

Implications of Recent Maryland Birth Statistics

As in the rest of the United States, the number of live births to Maryland mothers, both white and nonwhite, has decreased steadily in recent years and is now near the lowest level of the past decade.

YEAR	LIVE BIRTHS	BIRTH RATE*	FERTILITY RATE**
1960	77,496	24.8	117.8
1961	78,190	24.5	116.2
1962	76,325	23.6	114.3
1963	78,146	23.2	112.3
1964	79,003	22.8	109.1
1965	74,137	20.9	99.7
1966	72,117	19.9	96.2
1967	69,726	18.9	90.5
1968	68,407	18.2	86.7
1969***	69,000	18.0	85.7

** Number of live births per 1,000 estimated population in specified year.*
*** Number of live births per 1,000 estimated female population ages 15 to 44.*
**** Preliminary.*

Active and extensive family planning programs have existed for some time in Baltimore, as well as in many of the counties, and now encompass the entire state. The resultant availability of the pill and various birth control devices to all population segments has patently played a key role in this decline. Another probable factor is the desire for smaller families, and the ability to attain this objective as reflected in the 42.3% drop between 1960 and 1968 in the number of births of fourth or higher order (from 24,000 to 13,847).

The propounded assumption that this decrease also reflects postponed rather than prevented births appears to be without merit. The birth rate, which relates the number of live births to the size of population, has decreased more than one fourth since 1960, from 24.8 to 18.0 per 1,000.

A somewhat more sophisticated measurement is the fertility rate, since its denominator is limited to the number of women in the child-bearing ages (between 15 and 44). This ratio has declined an average of about 3% a year, from 117.8 per 1,000 in 1960 to a currently estimated 85.7.

The size of this population group is now increasing substantially due to the large number of births in the years immediately following World War II. Because of this, even if the fertility rate decreases further, it is probable that the downward trend in births and in the birth rate will halt or even be reversed in the near future. In fact, preliminary data for 1969 indicate a slight increase in the number of live births although the birth rate continued to decrease. However, the probability that these will return to the high levels of earlier years is remote.

Opinions vary as to future fertility rate trends. Because of a continuing drop in the number of higher order births, Maryland's rate will probably decline for some time, most likely around the 3% a year noted in recent years. Should this be correct, the coming increase in the number of women in the reproductive ages will produce only a moderate rise in the number of births.

The effect of the liberalized abortion law enacted in 1968 is difficult to ascertain. Data indicate that the number of legally performed abortions has been increasing and will probably continue to go up in coming years. Despite this, Maryland's abortion rate is still greatly exceeded by those foreign countries where this procedure is legally permissible and readily attainable. It is, therefore, not possible to determine whether the increase in hospital-performed abortions merely reflects a shift from other previously employed resources or represents a true rise.

Declining fertility rates among all population groups have important implications. For example, maternity wards in Maryland hospitals currently are operating at an average occupancy rate of approximately 60%, a figure which should not rise significantly in coming years. Greater economy and efficiency of operations may therefore be achieved by the conversion of some maternity wards to other uses.

Similarly, consideration might be given to amalgamating or redirecting some pediatric services. Construction of elementary schools, a major capital cost of local government, might be limited in most cases to the replacement of obsolete buildings and to building units in new residential areas. This could release funds for the establishment or expansion of other programs. School boards should find recruitment and retention much simpler than in past years while upgrading faculty levels and reducing teacher-pupil ratios.

One direct effect of the reduction in births has already become apparent. Proportionally, the decrease has been greatest in births of fourth or higher order, many of which have been traditionally to mothers in high-risk groups. Maryland's decline in infant mortality rates in recent years can, in part, be attributed to this. It probably has had the same effect elsewhere as well.

Further improvement in this population index in coming years, resulting from a continuing decrease in higher order births, can be reasonably anticipated. In fact, it is quite possible that Maryland will be able to match the record low rates reported by some foreign countries.

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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Osteoarthritis of the Lumbar Spine

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Degenerative changes in the spine affect the intervertebral disks and the facet joints. There are several factors that will predispose to the development of osteoarthritis of the lumbar spine. Treatment for acute symptoms include bed rest, analgesics and physical therapy. If conservative treatment fails and if the disabling pain and nerve root signs are present, surgical treatment is indicated.

The lumbar spine, like other supportive structures, is susceptible to degeneration with advancing age.

Degeneration occurs in the cartilaginous portions of the spine and the severity varies in degree in different individuals. Some investigators have postulated that the degree of degeneration seems to be favored by heredity and by concomitant systemic conditions.

Degenerative changes in the spine affect two intervertebral articular systems: the synchondroses (intervertebral disks) and the diarthrodial (facet) joints.[1]

With advancing age, the nucleus pulposus undergoes degeneration and is fissured and deformed. It is gradually replaced by fibrous tissue. The loss of the cushioning effect of the intervertebral disk subjects the articular cartilage of adjacent surfaces of vertebral bodies to excessive pressures. Reactive new bone formation results. Subsequently, there is a growth of bony spurs at the periphery of the vertebral bodies. These marginal spurs may be located at the anterolateral aspect of the posterior portion of the vertebral bodies where they may protrude and embarras the spinal nerve roots. Occasionally, adjacent osteophytes may form bone bridges and unite, so that motion is eliminated at the affected area.

Narrowing of the disk anteriorly puts much stress on the facet joints posteriorly. The articular cartilage of the facets is gradually worn away. Narrowing of the facet joints follows and the opposing surfaces become irregular and sclerotic. As the degeneration progresses, the articular processes usually subluxate and the inferior facet may impinge upon the nerve root. The marginal spurs of vertebral bodies adjacent to the intervertebral foramen may also compress the nerve root. Degenerative changes may also affect the annulus fibrosus so that disk protrusion may result.

Etiology

There are several factors that predispose to degenerative arthritis of the spine: [2]

1. *Direct Trauma to the Lumbar Spine*

In addition to overt bony damage in fractures and dislocations, there is often accompanying damage to the surrounding soft structures and articular surfaces.

2. *Indirect Trauma*

Repeated flexion and extension movements and excessive carrying of loads, particularly when carried to the point of fatigue, predispose to degenerative changes.

3. *Mechanical or Postural Activity*

When proper posture is maintained, body weight is distributed evenly and muscle activity and fatigue are minimal. Improper posture demands increased muscle activity. Excessive stress is imposed on the ligamentous structure of the spine and fatigue appears quickly. The facets subluxate and the articular surfaces gradually undergo degeneration. Deformity in one segment of the spine, as in thoracic kyphosis, increases lumbar lordosis

and imposes heavy strain upon the lumbosacral area. Other deformities, such as scoliosis, pelvic obliquity, and leg length discrepancy, have the same effect. The lumbar spine, which supports the maximum body weight, is also subject to rapid deterioration in obesity.

4. *Antecedent Disease of the Spine*

Conditions that have violated the structural integrity of the lumbar spine will predispose to the development of osteoarthritis. Granulomatous or pyogenic infections or both can damage the spine directly. The infection usually involves the disk space initially and spreads to involve the vertebral body.

Clinical Features

The patient complains of pain and stiffness in the low back area. In the initial course of the disease the stiffness seems to be relieved by activity. The pain is aggravated by bending and lifting of heavy loads. It is relieved gradually with periods of rest. The character of the pain varies and it may be localized or diffuse over the low back area. When there is nerve root irritation, the pain is usually referred to the lower extremity and is aggravated by coughing, sneezing, and straining. Its location follows a dermatomal pattern. There may be accompanying numbness, paresthesia, and muscle weakness.

The range of motion of the lumbar area is limited in all directions. Forward bending is accomplished primarily by flexion of the hips. The normal lumbar lordosis is diminished and the area may be flattened. There may be an accompanying reflex spasm of the paraspinal muscles. If the spasm involves only one side, a scoliosis is present. Localized tenderness, on deep pressure or fist percussion, may be elicited over the affected area. In the presence of nerve root irritation, a positive straight leg raising test is usually present. Sensory, motor and reflex alterations define the specific nerve root involvement.

Radiological Features

These changes are usually seen in the facet joints and the disk interval. There is narrowing of the apophyseal joint at the affected level. The articular cortices are dense and irregular and there is spurring of the margins. The intervertebral space is narrowed and the opposing cortices are dense and irregular. Schmorl's nodes may be present. These are radiolucent defects extending into the subcortical cancellous bone of the vertebral bodies. They are composed of disk material that has penetrated through the soft vertebral end plates. Spurs at the vertebral margins may fuse with one another. Lumbar myelography may help in the diagnosis and localization of disk herniation.

Differential Diagnosis

Since there are so many conditions that can give the same clinical and objective findings, it is important that the correct diagnosis be obtained. For the differential diagnosis, there are four major categories that must be considered in any back problem:

1. *Developmental*

Spina bifida, spondylolisthesis, scoliosis, and congenital malformations are seen in children and young adults.

2. *Mechanical*

There is usually a history of injury. Pain is usually relieved by rest and aggravated by motion.

3. *Inflammatory*

This occurs in the form of tuberculosis, osteomyelitis, etc.

4. *Neoplastic*

This may be primary or metastatic and is more common in elderly patients.

The clinical picture and laboratory findings usually help in reaching the diagnosis.

Treatment

The condition is usually treated with conservative measures. Treatment for acute symptoms should include rest in bed and physical therapy. Slight flexion of the hips and the knees or the Fowler's position is usually the position of greatest comfort. A firm mattress with a board beneath it relieves painful tension and gives support to the back.

Rest in bed should be continued for two to four weeks or until muscle spasm and pain have been relieved. Moist heat is usually effective in reducing the painful muscle spasm. Massage may be used following application of heat. It has been reported by some investigators that the physiological effects of massage are mediated through reflex dilatation of the superficial capillary vessels and relaxation of muscles with gentle stroking.[3] Mechanically, it may also accelerate venous and lymphatic return of the involved part. Pelvic traction or bilateral Buck's traction is recommended by some. It is felt that the benefit obtained from this is not due to traction, but the fact that the patient is resting in bed.[4]

Drugs are used for the control of pain and muscle spasm. For the relief of pain, salicylates, or some of the new synthetic, non-narcotic analgesics are used. Muscle relaxants with tranquilizing effect are effective since most of these patients may also have accompanying emotional tensions. Because of their inactivity, patients at complete bed rest may develop constipation. These patients may need laxatives.

Exercise is usually not indicated during acute episodes since it may aggravate the pain. As soon as the irritability has subsided, moderate exercise to strengthen the back, abdominal and leg muscles is indicated. Exercises should never be carried to the point of fatigue. Excessive exercise is harmful. Dis-

comfort persisting for more than one or two hours following exercise indicates that it has been excessive and should be curtailed.[5]

A corset or brace provides support to the back and also aids in maintaining good posture. Although braces are beneficial they should never be used indefinitely since they may cause muscle atrophy through disuse which, in turn, has a deleterious effect on the lumbar spine. The brace is gradually discarded as symptoms decrease. Before the patient starts to perform his normal activities, he should be examined to see if he has good muscle control and has regained full back motion.

In cases of subacute attacks, during which the symptoms and signs are not severe, ambulatory treatment may be utilized. Treatment is almost the same as above, except that patients are not kept at complete bed rest and the physiotherapy is not as vigorous. Patients with known osteoarthritis of the lumbar spine should be advised to avoid trauma or strain to the back. Heavy lifting or vigorous sports must be avoided. Factors causing excessive strain to the back are corrected together with faulty posture and poor work habits. Obese patients should be encouraged to undergo a program of weight reduction.

Occasionally, a program of conservative treatment fails. If the pain or nerve root signs become disabling, surgical treatment may be necessary. Compression of nerve roots is relieved by foraminotomy. In this operation, decompression of the intervertebral foramina requires removal of much of the facets. This procedure may be combined with a spinal fusion.

Some believe that because of the pre-existing narrowing of the disk spaces and osteophytes at the vertebral margin, stability of the spine is not impaired so that arthrodesis is not indicated. If the osteophyte at the posterior margin of the vertebral body impinges on the nerve root and is accessible, it is removed, although unroofing the foramen is usually sufficient.

When the problem lies only at one site, and if the source of recurrent problem and instability is evident, arthrodesis of the area relieves the symptoms permanently. This is usually true in localized arthritis of traumatic or degenerative origin as in the lumbosacral area.

In the presence of disk protrusion with major neurologic deficit or intolerable pain, removal of the protruding material is mandatory. Advanced age of the patient is no contraindication.[6] Remarkable relief is usually obtained and these patients tolerate surgery well and the prognosis is good.

There is varying opinion with regard to spinal fusion after disk removal. Some of the factors to be considered are age of the patient, occupation, general condition, stability, etc. It is usually preferable not to fuse since foraminotomy is less extensive and convalescence is rapid and easier.

REFERENCES

1. Sokoloff, L.: "The Pathology and Pathogenesis of Osteoarthritis", *Arthritis and Allied Conditions,* ed 7, Ed. Hollander, J. L.: Philadelphia: Lea & Febiger, 1966, p. 849-869.
2. Turek, S. L.: *Orthopaedics,* ed 1, Philadelphia, J. B. Lippincott Co., 1959.
3. Bowie, M. A.: "Physical Therapy in Arthritis", *Arthritis and Allied Conditions,* ed. 7, Ed. Hollander, J. L., Philadelphia, Lea & Febiger, 1966, pp 481-527.
4. Youel, M. A.: Effectiveness of Pelvic Traction, *J Bone Joint Surg* [Amer] **49-A:** 204, 1967.
5. Abrams, N. R.: "Treatment of Osteoarthritis", *Arthritis and Allied Conditions,* 7th edition, Ed. Hollander, J. L., Philadelphia, Lea & Febiger, 1966, pp 886-895.
6. Simon, S. D., et al: "Lumbar Disk Surgery in the Elderly (Over the age of 60)", *Clin Orthop* **41:**157-162, 1965.

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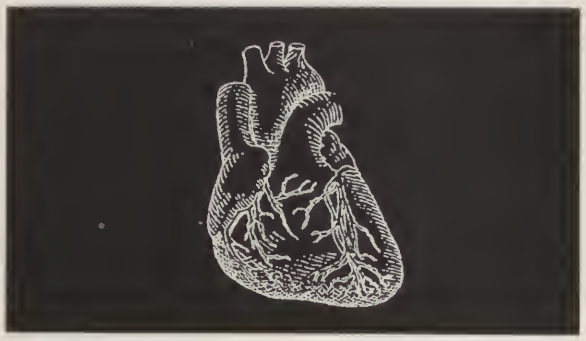
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the heart page

Dietary Salt (Sodium Chloride) Intake and Arterial Hypertension: (Part) 2

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The observations and clinical studies of the role of salt in hypertension must be extended to balance studies in human beings with essential hypertension and those without it. First, it must be noted that the determination of salt intake in humans is extremely difficult. It must be done indirectly, that is, by urinary output which only measures the minimal salt intake. The amount of sodium lost from the skin and other sources can only be estimated. The figures given earlier for certain human groups were based upon urinary output. The point naturally arises as to whether salt appetite is induced or inherited. Experimental studies have shown that this is an acquired phenomenon. Hypertensive patients respond differentially to salt or water loading. Hypertensive patients will eliminate a greater proportion of a salt and water load than normotensive patients. This is nonspecific and may be the effect of arteriolar pressure on increased natriuresis. Studies show that the hypertensive patient excretes a larger amount of sodium than the normotensive person. However, one must not deduce that sodium intake is involved with the pathogenesis of hypertension. In other words, whether this is a cause or effect has not been determined. It could very well be the *effect* of hypertension rather than the *cause*. However, there seems to be no difference between salt requirements in the hypertensive and normotensive patients. Also, no difference between discomfort from salt restriction exists in these two population groups. In studies of hypertensive groups, the salt intake may be high because these patients put out more salt. Therefore, they may have to take in more to maintain metabolic balance. Again, it should be mentioned that potassium may have an antagonistic effect as may have calcium, as far as sodium is concerned. Also, recent observations have suggested that cadmium may have an effect upon hypertension, at least in rats. Rats fed cadmium in their drinking water developed hypertension in a significant number of cases. Cadmium was found in the renal proximal tubules and tended to facilitate sodium reabsorption. Thus, there may be some interaction between cadmium and sodium as a possible etiologic factor in hypertension. One source of cadmium is water left standing in galvanized pipes. The cadmium/zinc ratio may, indeed, be the important factor rather than cadmium *per se*. In 1960, Schroeder [7] reported a correlation in the death rate in the United States with the hardness of water which showed a possible negative relationship. These studies and their significance to the present problem will have to be clarified by further investigation.

The studies cited may be significant to clinical application and public health. By way of review: In populations in which hypertension is a major health problem, dietary sodium may, indeed, be positively associated as a cause. However, the difficulty in measuring sodium intake has been mentioned, as well as the importance of many other factors that may play a role in a given population. Nevertheless, one cannot deny that this particular ion may be important in arterial hypertension. Is there enough information presently available to advise restriction of salt in the diet of the general population as a public health measure? Before one can make this recommendation, it is important to determine whether there could be any possible harm from such restrictions. Balance studies done by Dahl and others have shown that people maintained

on a 275 to 375 mg sodium chloride diet daily are able to maintain normal metabolic balance. Under ordinary circumstances the adaptive mechanisms of the body are so exquisitely effective in conserving salt that intakes of 1 gm to 2 gm a day are more than sufficient for metabolic needs, including periods of growth.[5] Many people, such as Eskimos, American Indians, and certain tribes in Africa, ate only natural foods without salt for years. These people could not have eaten more than 5 gm of salt a day. From a therapeutic point of view, Grollman and Harrison,[8] in 1945, showed that there was an antihypertensive effect of sodium depletion in the rat. Various diets without sodium, such as rice, soy bean, peanut, or potato, resulted in a decrease in blood pressure which could be reversed by adding 2% sodium chloride to the diet of these rats. Survival rates were longer if the lowered blood pressures were maintained. The same was demonstrated less dramatically in dog experiments by the use of natriuretic drugs. From a human point of view, results are quite conflicting because of the unreliability of random samples of blood pressures, the difficulty in dietary control, and the difficulty in estimating the non-urinary sodium loss. Of course, the rice diet of Kempner,[9] which is a low sodium diet, reduced the blood pressure to lower levels in approximately two thirds of his patients.

There is little doubt that restriction of the sodium intake can lower the blood pressure in hypertensive patients. The experience with the diuretic drugs also proves that this can be accomplished. Thus, the use of diuretics in combination with a restricted sodium diet has a definite therapeutic benefit in the hypertensive patient. However, it would be presumptuous to think that this will correct any defects since the actual defect in arterial hypertension is not known. One may say that the restriction of sodium in the diet has a beneficial effect upon blood pressure and may indeed affect the manifestations of the disease but does not affect the fundamental underlying disturbance.

Unless the sodium restriction is severe, one probably would expect very few side effects. Certainly in hypertensive patients this has not been a major problem. However, in the normotensive patient, if the sodium restriction goes below a certain critical level, one may expect anorexia, headache, lassitude, general malaise, nausea, and possibly muscle cramps. Will the prophylactic reduction of sodium in the diet influence the development of essential hypertension? This is a public health problem and one which is probably associated with a number of serious implications. There are not sufficient data to definitely support this possibility affirmatively. However, since a large number of patients in the population are hypertensive without knowing it, and since the blood pressure apparently can be reduced by sodium restriction, it would seem that this would indeed be a beneficial step. Could this be harmful to the normal or ill individual? In certain conditions salt loss may be critical, such as in Addison's disease, but otherwise the possible gains outweigh the liabilities.

Conclusion

Some of the experimental and clinical data support the fact that dietary sodium may indeed be important in the pathogenesis of human essential arterial hypertension. However, it also has been pointed out that this theory is not as clear-cut as it may appear on the surface. There are probably multiple factors operating together and interacting with each other to produce this important clinical entity. To say that any one of these, specifically sodium, is sufficient within itself to produce arterial hypertension is presumptuous. To even say, at this point, that sodium is necessary for the production of arterial hypertension may likewise be presumptuous in that there are hypertensive states that do not respond to either an increase in the sodium excretion or a decrease in the sodium intake. Finally, it seems that no data are available that would tend to mitigate against the widespread employment of restricted sodium diets as a prophylactic public health measure.

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Advertisers in This Issue

A & F Nurses Registry 32
Aids For Hearing, Inc. 108
American Office Equipment Co., Inc. 52
Arch Laboratories 93
Arundel Federal Savings & Loan Assoc. 14
Atlantic Sands Motel 52
Baltimore Federal Savings & Loan Assoc. 39
Baltimore Hilton Hotel 34
Baltimore Nurses Exchange 110
Baltimore Oxygen Supply Co., Inc. 94
Becton, Dickinson & Co. 29-30
Belvedere Hotel 82
Breon Laboratories 18
Bryman School 111
Burroughs Wellcome & Co. 85
Campbell Soup Co. 45
Capital Savings & Loan Assoc. 94
Oscar Caplan & Sons 8
Carlton Corp. 33
Cobb-Woods Services 38
Coca-Cola Bottling Co. 25
Community Health Facilities, Inc. ..... Cover 2
Conal Pharmaceuticals 48
Connecticut Mutual Life Insurance Co. 7
Herbert Cox—Correct Shoes 108
Credit Service International, Inc. 38
Diplomat Motor Hotel 38
Dow Chemical Co. 84
Dulaney Towson Nursing & Conv. Home 34
Eleven East Chase Street Corp. 108
Embassy Dairy 107
Esplanade Apartments 111
Eutaw Savings Bank 14
Flint Laboratories 12
Forty West Porsche Audi, Inc. 82
Franklin Uniform Co. 96
Geigy Pharmaceuticals 83
A. Gude Sons Co. 25
Harrison Hall 25
Herget & Co., Inc. 94
Hoffman Green Motors, Inc. 105
House in the Pines Nursing Homes ..... Cover 3
Hynson, Westcott & Dunning, Inc. 1
Lederle Laboratories 2, 26-27, 93, 95
Eli Lilly & Co. 4
Martin Motors, Inc. 110
Martin's Restaurant, Inc. 111
Milton Inn 49
Monarch Lincoln Mercury 80
National Drug Co. 15-16, 97-98
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Read's Drug Stores 49
Resinol Chemical Co. 82
A. H. Robins Co. 35-36, 91
Roche Laboratories ..... 50-51, Cover 4
Sakura Palace Restaurant 108
Schering Corp. 53-54
Manuel Schwartz Hearing Rehabilitation 94
G. D. Searle Co. 46-47
Security Business Services, Inc. 52
Special Diet Shop 105
Sterling Lighting Co. 94
Stuart Pharmaceuticals 92
Mano Swartz—Furs 8
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Timonium Chrysler Plymouth 11
Tio Pepe Restaurant 94
Towson Telephone Secretaries 38
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Unique Design by Hilbert, Inc. 49
D. Stuart Webb Advertising Services, Inc. 111
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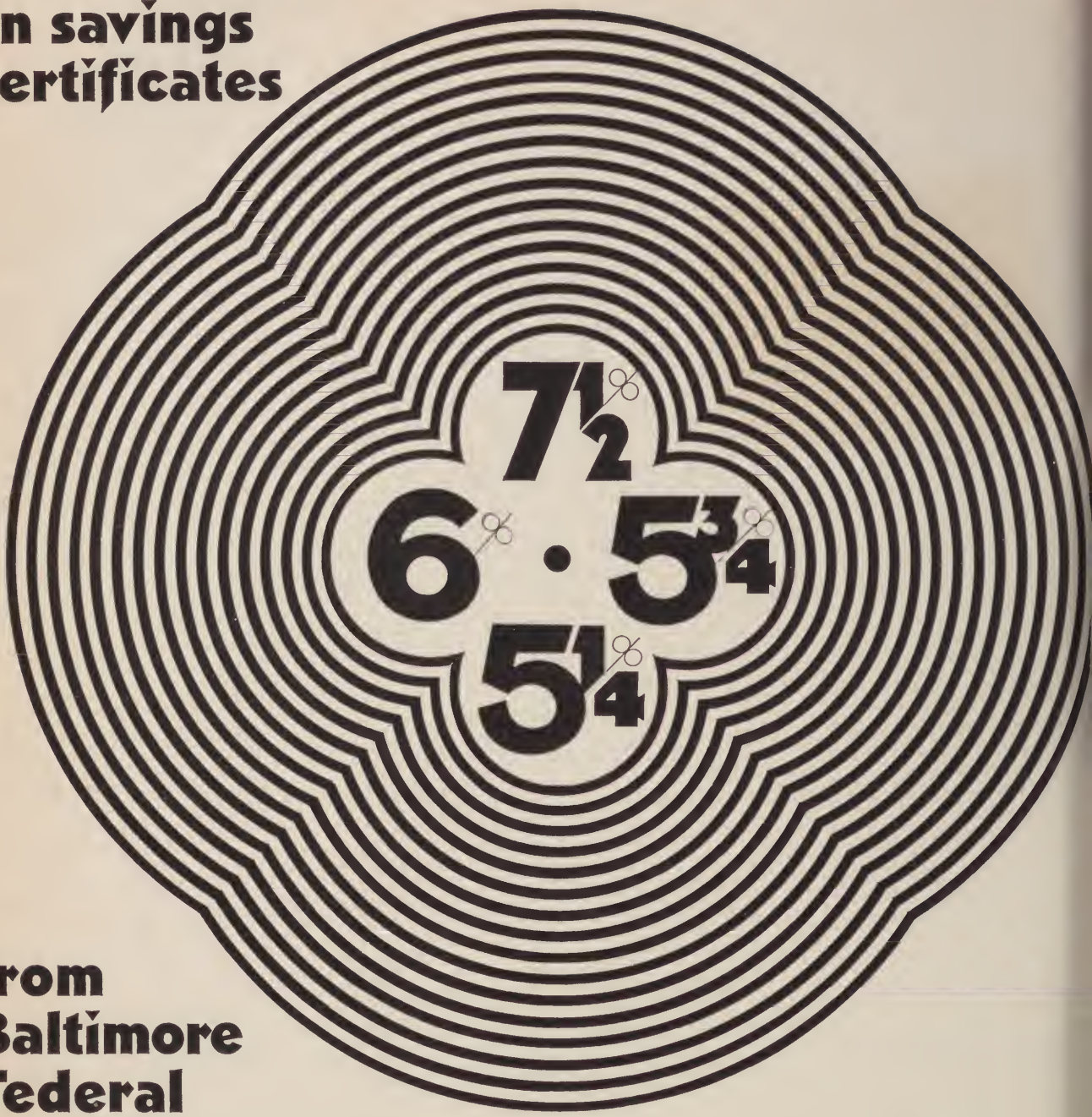
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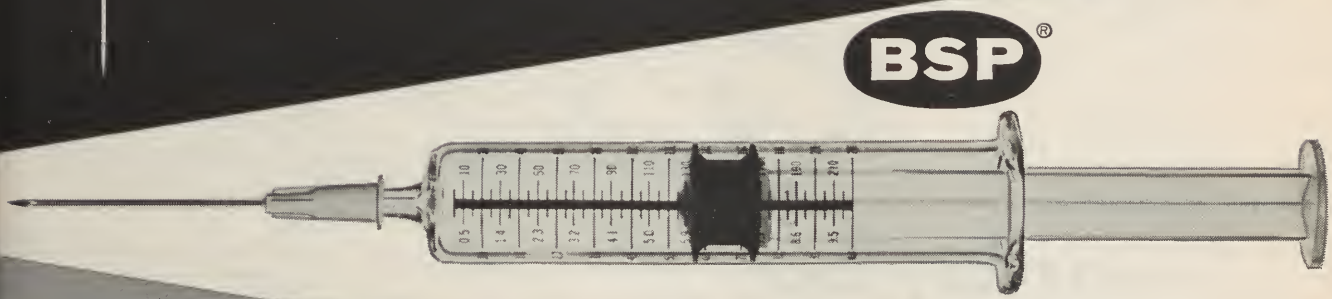
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CONTENTS:

Cerebral Training, Ernst Schmidhofer, MD 51

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Neurological States Masquerading As Psychoses, Dietrich Blumer, MD 55

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Diagnosing Organic Psychosis, Lindbergh S. Sata, MD 61

"This paper is concerned with separating those patients with true psychiatric problems from those who have been mistakenly classified as psychiatric, when they unfortunately have organic reasons for their problems—subdural hematomas, brain tumors, multiple sclerosis, etc."

Organic Versus Functional Psychosis: Differential Diagnosis, Virginia Huffer, MD 65

"Physicians frequently encounter patients showing disturbed behavior for whom a differential diagnosis may be both difficult and crucial. This can be especially true as it relates to functional versus organic or toxic psychoses."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 71

Rehabilitation Notes—Osteoarthritis of the Knee, Renato S. Lapidario, MD 75

Tuberculosis—Examination of Sputum Cells 79

Heart Page—Diagnosis of Hyperlipidemia, Simeon Margolis, MD 85

Baltimore City Health Department—Meeting the Challenges of Public Health in Baltimore City, Joseph Gordon 89

Library Page—Visit to Western Maryland; New Accessions 95

Alcoholism Page—Alcoholism: Diagnosis 99

Maryland State Department of Health and Mental Hygiene—Maryland's Mental Hospitals Six Years After Desegregation 103

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Annual Meeting News 5

Advertising Regulations 7

Executive Director's Newsletter 9

Doctors Take Note 13

Annual Meeting Scientific Exhibit Form 17

Component Society News 19

Medical News 25

1971 Semiannual Meeting News 31

Annual Meeting Hotel Reservation Form 32

The Month In Washington 35

Book Reviews 47

Letter to the Editor 73

MEDIC 74

Maryland Association of Medical Assistants 81

Baltimore Association of Medical Assistants 81

Information for Authors 105

Seminar on the Medical Aspects of Sports 106

Classified Advertising 107

Advertising Index 108


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executive director's newsletter

October, 1970

ONE-MAN CORPORATIONS

Despite IRS surrender on tax treatment of professional corporations, many attorneys advise against incorporation of one and two-man practices, and of practices not in the top income range. These attorneys cite initial costs of incorporating, the constant red tape, and the problems arising when a physician member dies, as reasons not to incorporate. These same attorneys point to the legal profession itself, noting that lawyers with moderate incomes are staying off professional corporation bandwagons.

SOME GROUPS ILLEGAL

The State Department of Assessments and Taxation is now looking into the professional corporations that have been formed in Maryland. Some do not comply with certain sections of the law, such as the use of PA in their professional name. Others include individuals as shareholders or incorporators who do not hold valid licenses to practice the profession in which the incorporation is made.

CONFUSION ABOUNDS

Non-mathematically inclined physicians can benefit from the following explanation of how Medicare benefits are derived.

In response to a communication from a physician, Blue Shield has advised:

> "The median is the value point at which half the cases in the distribution fall above and half fall below. Thus, if a given service in 1969 which you reported five times, had charges of $75, $125, $135, $150 and $150, the median would be $135.
>
> "The median is higher than the simple average of the lowest and highest, though the mode (the most frequently occurring value) is higher than the median. For comparison purposes only, the arithmetic mean...would be $127."

There you have it.....I'm not a mathematician and I'm still confused.

INCOME COMPARISON

The Wall Street Journal in its Monday, August 24, issue reported that United Air Lines pilots reached agreement

INCOME COMPARISON (cont'd)

with the airline for a salary of $57,000 a year for an 80-hour month. Fringes are extra. This salary is for a 747 pilot; while pilots of the 737 will receive $3,130 a month; 737, three engine, $3,348 a month; and DC8 pilots, $3,793.

RESOLUTION DEADLINE

Resolutions for consideration at the Faculty's Annual Meeting scheduled for May 14, 1971, must be in the Faculty office at least eight weeks prior to that date. This means that resolutions must be received by Friday, March 19, 1971.

1971 SEMIANNUAL MEETING

The El Conquistador Hotel and Club in Las Croabas, Puerto Rico, will be the site of the 1971 Semiannual Scientific Meeting from September 15 to 19. The House of Delegates business session will be held in Maryland, with the place and time yet to be determined.

1971 ANNUAL MEETING

The 173rd Annual Meeting of the Faculty will be held at the Civic Center in Baltimore, May 12, 13, 14. More space will be available for SCIENTIFIC EXHIBITS than ever before. See page 17 of the October Journal for an application form or contact the Faculty office.

MALPRACTICE INSURANCE

Plans are rapidly nearing completion for a study of the Professional Liability situation in Maryland over the past ten years. Recommended to and approved by the Medical Economics Committee and the Council, this study would attempt to identify the "typical" physician or lawyer involved in court action. It would also investigate such factors as the educational background of those professionals sued, the justness of the suits, and the amount of settlement that finally reaches the claiman

In other developments, the Louisiana Insurance Commissioner recently approved increases in the premiums in that State's program which is substantially higher than Maryland's. For Class III, 100,000/300,000 coverage would be $905.97, compared to Maryland's $489 under the Faculty program.

John Sargeant

Executive Director

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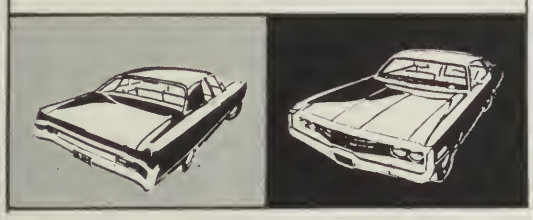
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Doctors take note...

OCTOBER 16-17, 1970
EASTERN SECTION, AMERICAN THORACIC SOCIETY

Annual Meeting: Belvedere Hotel, Baltimore, Md. For further information, contact Frank Jones at the American TB Association: 685-6484 (Balto.).

OCTOBER 17-22, 1970
AMERICAN ACADEMY OF PEDIATRICS

39th Annual Meeting: San Francisco, California. Contact: American Academy of Pediatrics, Department of Public Information, 1801 Hinman Ave., Evanston, Illinois 60204.

OCTOBER 18-23, 1970
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

2nd Scientific Assembly: Las Vegas, Nevada. The assembly will focus on the delivery of primary care in the hospital emergency department. For information, write: Executive Secretary, 120 West Saginaw, East Lansing, Michigan 48823.

OCTOBER 18-NOVEMBER 12, 1970
AMERICAN COLLEGE OF PHYSICIANS

11th International Congress of Internal Medicine and Post Convention Tour Around the World: New Delhi, India. Cost per person: $1,935. Contact: American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

OCTOBER 20-23, 1970
AMERICAN COLLEGE OF PHYSICIANS

Course—Neurologic Aspects of Internal Medicine: Duke University Medical Center, Durham, North Carolina. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

OCTOBER 23-24, 1970
HEART ASSOCIATION OF MARYLAND

Annual Meeting: Sheraton Motor Inn, Hagerstown, Maryland. Contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

OCTOBER 25-29, 1970
AMERICAN COLLEGE OF CHEST PHYSICIANS

2nd Fall Scientific Assembly: Los Angeles, Calif. Contact: Alfred Soffer, MD, 112 E. Chestnut St., Chicago, Ill. 60611.

OCTOBER 26-28, 1970
AMERICAN COLLEGE OF PHYSICIANS

Course—New Concepts in Basic and Applied Hematology: Department of Internal Medicine, Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania. Contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

OCTOBER 27-30, 1970
AMERICAN ASSOCIATION OF BLOOD BANKS

23rd Annual Meeting: San Francisco, Calif. Contact: American Association of Blood Banks, Central Office, Suite 1322, 30 North Michigan Ave., Chicago, Ill. 60602.

OCTOBER 28-30, 1970
HEART ASSOCIATION OF MARYLAND

Three Days of Cardiology for Nurses: George Washington Hotel, Jacksonville, Florida. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201.

OCTOBER 29, 1970
NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE

6th Annual Symposium on Air Pollution and Respiratory Diseases: Thruway Hyatt House Hotel, Albany, New York. Contact: New York State Action for Clean Air Committee, 105 East 22nd Street, New York, New York 10010.

OCTOBER 29-30, 1970
AMERICAN PUBLIC HEALTH ASSOCIATION

98th Annual Meeting: Houston Civic Center, Houston, Texas. Contact: Mrs. Marion Paul, American Public Health Association, 1740 Broadway, New York, N.Y. 10019.

OCTOBER 29-31, 1970
AMERICAN COLLEGE OF GASTROENTEROLOGY

Postgraduate Course—Gastroenterology: Statler Hilton Hotel, New York, N.Y. Contact: American College of Gastroenterology, 229 Broadway, New York, N.Y. 10017.

OCTOBER 29-NOVEMBER 1, 1970
PACIFIC COAST FERTILITY SOCIETY

18th Annual Meeting: Scottsdale, Ariz. Contact: Pacific Coast Fertility Society, 5410 Wilshire Blvd., Los Angeles, Calif. 90036.

OCTOBER 30-31, 1970
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

2nd Annual Birth Defects Symposium: Gainesville, Florida. Contact: Mrs. Betty L. Howard, Division of Postgraduate Education, J. Hillis Miller Health Center, Gainesville, Florida 32601.

NOVEMBER 2-5, 1970
INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION OF NORTH AMERICA

55th Annual Scientific Assembly: Palmer House, Chicago, Illinois. The assembly will include scientific luncheons and alternate evening programs. It is accredited by the AAGP and the AMA Council on Medical Education. For further information, write: Morris Fishbein, MD, President, Interstate Postgraduate Medical Association, 307 N. Charter St., Madison, Wisconsin 53715.

(Continued on page 40)

The girth control pill



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Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic cardiovascular effects reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. Allergic phenamena reported include such conditions as rash, urticaria, ecchymosis, and erythema. Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

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One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

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Specific therapy for night leg cramps

Q915A

SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 12, 13, 14, 1971
Baltimore Civic Center

More space is available than in former years. However, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

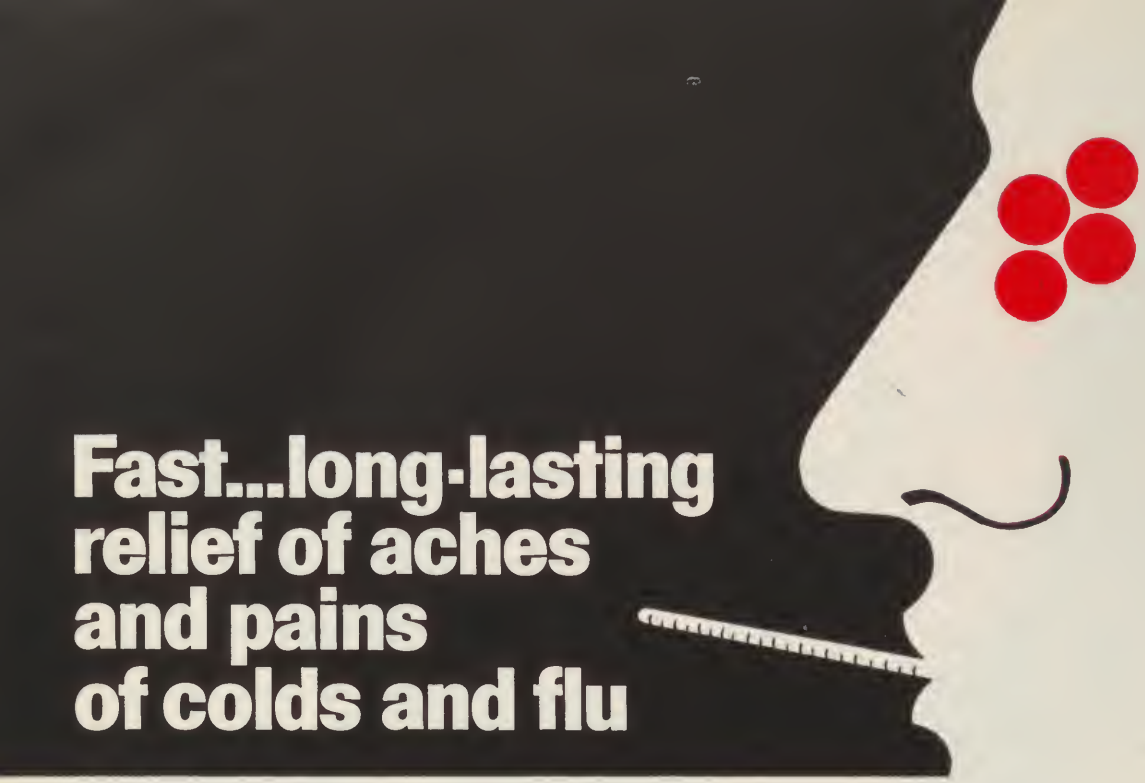
7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS



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ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

November Meeting News

Thursday **November 5, 1970** **8:30 PM**
Osler Hall, 1211 Cathedral Street, Baltimore

"Environmental Health Problems in the State of Maryland"
Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene for the State of Maryland

Agenda for the Business Meeting

1. Adoption of minutes of October 1, 1970 meeting
2. Action on Bylaws amendments, presented October 1, 1970
3. Action on resolution requiring formation of scholarship fund, presented October 1, 1970
4. Presentation of Nomination Committee report and acceptance of additional nominations from the floor
5. Nominations for four members to serve on the 1971 Nomination Committee
6. New business

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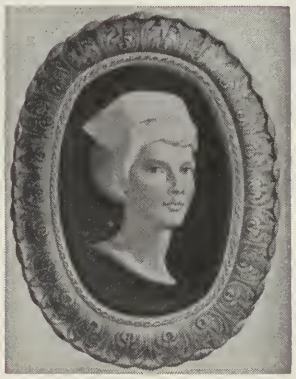
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The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.



Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED
Tablet in bottles of 100, 500 and 5000
Capsule in bottles of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

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Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

/2/68—After 11 days of treatment. rythema is seen at site of keratoses. In ddition, numerous lesions not apparent rior to therapy have become manifest y sharply defined reactions. Intervening kin, also treated, shows no response to herapy.

/19/69—One year after cessation of herapy. Skin appears clear with no evi- ence of scarring. Examination reveals ck of recurrence or the formation of ew lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning the site of application. Other local reactions included dermati scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scali swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice d with a nonmetal applicator or suitable glove in an amount of solution or cream sufficient to cover the lesion. When Efudex applied to a lesion, a response occurs with the following sequ erythema, usually followed by vesiculation, erosion, ulceratic necrosis and epithelization. The lower frequency and intensit activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammat reaction reaches the erosion, necrosis and ulceration stage, a which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of lesion may not be evident for 1 to 2 months following cessatio Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—conta 2% or 5% fluorouracil on a weight/weight basis, compounde with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil i vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (met and propyl).

Clinical Studies: The effectiveness of the three preparations determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions w complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of lesions; and 5% Cream, 5.6% of 160 lesions. Because of the to potential of fluorouracil, some physicians preferred to use the solution when large areas were to be treated. Approximately of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequat treatment.

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MEDICAL NEWS

Two research grants totaling almost $15,000 were awarded to two Maryland physicians by the National Tuberculosis and Respiratory Disease Association.

George Comstock, MD, of Hagerstown, received a grant of $4,837 for his continuing work in determining the relationship of respiratory diseases to the amount of air pollution in urban cities.

The other two-year grant of $10,088 was awarded to **Norman E. Morrison, PhD,** microbiologist and Associate Professor of Pathobiology at The Johns Hopkins University School of Hygiene and Public Health. Dr. Morrison's research will seek new and more efficient drugs to treat respiratory infections, particularly tuberculosis.

* * *

Six new physicians will help ease Washington County's physician shortage. **Henry L. Rogdon, MD, John W. Sloan, MD, Joseph C. Eshleman, MD, Eldon Leon Hawbaker, MD, John H. Hornbaker, Jr., MD,** and **John Wesley Wilson, MD,** will serve in the Emergency Coverage System of the Washington County Hospital.

* * *

William H. Danforth, MD, former Vice-Chancellor for Medical Affairs of Washington University in St. Louis, Missouri, has been appointed to serve on the National Advisory Heart and Lung Council of the National Heart and Lung Institute in Bethesda. Robert Q. Marston, National Institutes of Health Director, recently made the announcement.

* * *

Samuel L. Fox, MD, a Baltimore ophthalmologist, recently compared the treatment results of the topical use of a new antibiotic with that of a combination preparation used for years, in an article in the September issue of the *Southern Medical Journal.*

The article was entitled "Some Aspects in the Diagnosis and Management of External Infections of the Eye: Experiences with a New Antibiotic, Gentamicin."

* * *

Victor A. McKusick, MD, Chief of the Division of Medical Genetics at The Johns Hopkins University School of Medicine, was recently featured as a guest lecturer at a five-day postgraduate course sponsored by The American College of Physicians.

The course, "Basic Mechanisms in Internal Medicine", was given at the Medical College of Virginia.

* * *

Russell A. Nelson, MD, of Baltimore, **Stephen K. Padussis, MD,** of Lutherville, and **Austin B. Rohrbaugh, MD,** of Chevy Chase, were recently appointed by Governor Mandel to the state's Comprehensive Health Planning Council.

* * *

Alvin G. Lazen, MD, Assistant Professor of Physiological Chemistry, has been appointed Assistant Dean of The Johns Hopkins University School of Medicine.

As Assistant Dean, Dr. Lazen will spend part of his time reviewing and coordinating the finances of programs in the school's basic science departments that are paid for by sources outside the university.

* * *

John Neff, MD, has been appointed Assistant Dean of the Medical Faculty at The Johns Hopkins University School of Medicine.

Dr. Neff is an Assistant Professor of Pediatrics, who for the past year has been serving as student advisor. He graduated from Harvard Medical School and served his internship and residency at The Johns Hopkins Hospital.



Dr. Neff

* * *

Edwin L. Crosby, MD, Executive Vice-President and Director of the American Hospital Association, has been named the 1970 recipient of the AHA's Justin Ford Kimball Award in recognition of his outstanding encouragement of the concept of prepaid voluntary health care plans.

For more than three decades, Dr. Crosby has exerted strong influence on the development, integrity, and direction of Blue

Cross Plans. He has always emphasized the coalition of hospitals and Blue Cross Plans as a common service goal to the community.

Dr. Crosby received his masters and doctorate degrees in public health from The Johns Hopkins University.

* * *

Sister Alberta, DC, President of the St. Agnes Hospital Board of Trustees, announced the signing of a contract which grants exclusive rights to a group of **Emergency Room Physicians,** a Maryland professional corporation.

This group now has the right to provide the necessary licensed physicians required to staff the hospital's emergency room service. In doing so, the hospital has franchised the emergency room facilities to the corporation.

* * *

The National Clearinghouse for Drug Abuse Information has announced a 24-hour telephone service to answer requests for information about drug abuse.

The newly-created clearinghouse is a branch of the National Institute of Mental Health, Department of Health, Education, and Welfare. It serves as the federal focal point for drug abuse information.

The number to call for drug abuse information around the clock is 301-496-7171.

Bertram S. Brown, MD, NIMH Director, describes the clearinghouse as a "one stop store of information which must be put in the hands of parents, students, teachers, law enforcement officers, community leaders and all citizens concerned with the problem".

* * *

Joseph H. Miller, MD, has been appointed full-time Chief of the Section of Pulmonary Medicine at St. Agnes Hospital.

Recently, Dr. Miller completed a two-year Fellowship in Respiratory Diseases at The Johns Hopkins Hospital. He is a member of the American and Maryland Thoracic Societies, the Baltimore City Medical Society, and the Medical and Chirurgical Faculty of Maryland.

* * *

Every year in the United States alone, thousands of infants die suddenly and for no apparent medical reason. Only very recently has this sudden infant death syndrome, commonly known as **crib death,** become recognized as a real disease, not a vague, mysterious killer.

Bringing together reports from the leading researchers throughout the world who are dealing with this phenomenon, *Sudden Infant Death Syndrome,* edited by Drs. Bergman, Beckwith, and Ray, represents a major contribution to medical literature.

Russell S. Fisher, MD, Chief Medical Examiner of Maryland and a past president of the Medical and Chirurgical Faculty of Maryland, was one of the chief contributors to the book.

* * *

Robert Sandler, MD, was recently elected President of the Maryland Ophthalmological Society. **Stan L. Coleman, MD,** was elected Vice-President while **Gregory J. Sophocleus, MD,** was elected Secretary-Treasurer.

* * *

Robert Ralph Hylton, MD, of Camp Springs, was recently elected a Fellow of the American College of Anesthesiologists.

* * *

Persons planning to travel to South and Southeast Asia, the Middle East, North Africa, and Russia, should receive cholera immunization, according to **Howard Garber, MD,** Chief of the Division of Communicable Diseases, Maryland State Department of Health. He reported that a number of nations are now instituting quarantine procedures.

* * *

Neil O'Donnell, CP, former Chaplain and Chairman of the Department of Religion at St. Agnes Hospital, was recently awarded honorary residency at the hospital for eternity by the residents there.

The hospital's administrator, **Sister Alberta,** was also appointed Chief Honorary Resident for eternity.

* * *

Five Baltimore hospitals, seeking to improve efficiency and reduce operating costs, have formed a nonprofit corporation for joint purchasing of services and supplies.

The hospitals—Church Home, Good Samaritan, Greater Baltimore Medical Center, The Johns Hopkins, and Union Memorial —have made the venture unique by formalizing their agreement in a contract.

The new corporation is called **The Hospital Service and Supply Center, Inc.**

* * *

Doris M. Armstrong has been appointed Director of Nursing at The Johns Hopkins Hospital. Miss Armstrong had formerly served as Director of Operative and Acute Services there.

Miss Armstrong now heads all of the nursing personnel in the hospital and is responsible for the nursing care afforded to all of the patients.

* * *

The fact that people of all ages need protein everyday is emphasized in **"Protein",** a lively new six-minute color film which is available for loan from the Maryland State Department of Health and Mental Hygiene.

The film may be borrowed

without charge from the Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore. (Phone 383-3010, extension 8516.)

* * *

The President of The Johns Hopkins Hospital of Baltimore, **Russell A. Nelson, MD,** has been elected to the Board of Directors of Control Data Corporation.

* * *

Robert F. Wilson, Regional Vice-President of Hospital Food Management, has returned to The Johns Hopkins Hospital as Administrative Vice-President and Administrator.

Mr. Wilson had served on The Johns Hopkins staff from 1954 until August 1969. During the past year, he directed the management of dietary services for 34 hospitals in a nine-state Midwestern area.

* * *

Physicians again are being invited to submit original papers on headache or other pain in competition for the sixth annual **Harold G. Wolff Award** of the American Association for the Study of Headache.

The award, which carries with it a $1,000 honorarium underwritten by Sandoz Pharmaceuticals, may be divided among two or more researchers. It will be presented at the AASH's annual meeting in Copenhagen, Denmark, May 17-18, 1971.

Papers must be submitted by December 15, 1970, according to Perry S. MacNeal, MD, president of the association. Entries should be sent in duplicate to Donald J. Dalessio, MD, editor of the society's journal, *Headache,* 8878 Nottingham, La Jolla, California 92037.

* * *

John Sargeant, Executive Director of the Medical and Chirurgical Faculty of Maryland, spoke on the state's successful efforts to correct abuses of the medicare program at the Third National Congress on Medical Ethics held recently in Chicago.

* * *

Governor Marvin Mandel announced recently that Maryland has contracted for one of the **nation's most modern air pollution monitoring systems** as part of his continuing program to curtail air pollution and improve air quality in the state.

The Maryland system, called **"Airmon",** will provide for continuous telemetered air quality data from a network of eight sampling stations strategically located around the state.

* * *

Eastern Shore State Hospital, of the Maryland Department of Mental Hygiene, has been fully accredited by the Joint Commission of Accreditation for the maximum two years, according to an announcement by James E. Carson, MD, Commissioner of Mental Hygiene.

Neil Solomon, MD, PhD, Secretary of Health and Mental Hygiene, praised **Harold M. English, MD,** Superintendent of Eastern Shore State Hospital by commenting that, "this action by the commission certainly reflects great credit on your leadership and upon the devotion and efficiency of your staff."

* * *

James G. Zimmerly, MD, of Ellicott City, delivered a talk on a new meningitis vaccine at the American Medical Association's recent annual convention in Chicago.

Dr. Zimmerly and his colleagues first reported the results of their extensive field trials with the vaccine in the February issue of the *New England Journal of Medicine.*

* * *

Officers and board members of South Baltimore General Hospital recently issued a statement for strong support of appropriate hospital legislation needed at this time. The statement maintains that the approaches represented by U.S. Senate Bill 547 and House Bill 1082 are inadequate means to judge hospitals by or to set policy from.

* * *

Noting that it is probable that **changes in Medicare** will be enacted during this session of Congress, the Social Security Administration has instructed carriers to continue temporarily the existing levels for reimbursement of physicians and other suppliers of medical services under Part B of Medicare, which was due to be changed July 1.

Based on instructions issued in April, carriers had begun the operations needed to convert charge data accumulated in 1969 into new customary and prevailing charges that would be applicable beginning July 1.

* * *

Physicians and dentists participating in the **Maryland Medical Assistance Program** have been urged to prescribe drugs by their generic names so that pharmacists may dispense a quality product reasonably priced.

The request was made in a joint statement issued by the Medical and Chirurgical Faculty of Maryland, the Maryland Pharmaceutical Association, and the Maryland State Department of Mental Hygiene.

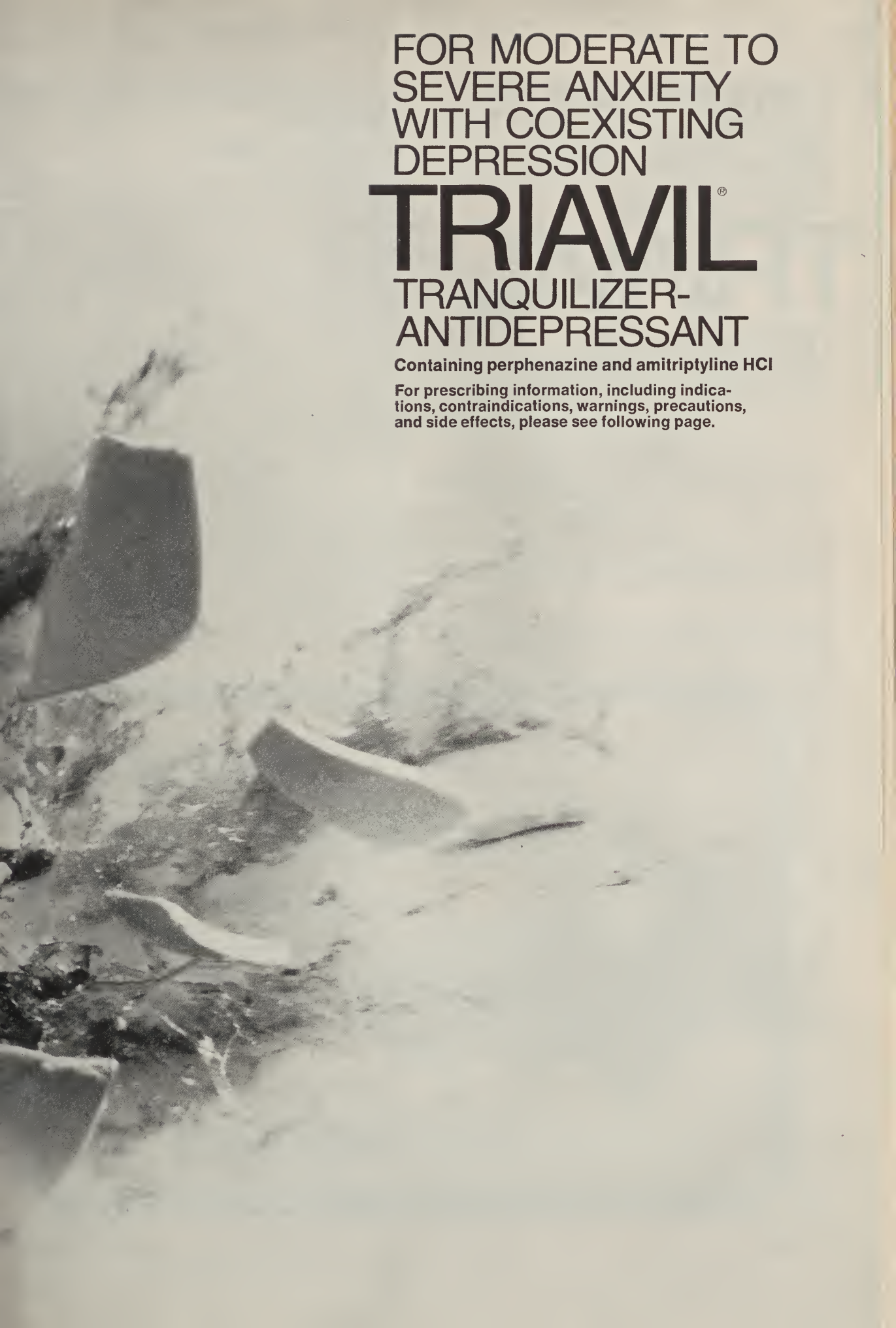
* * *

James L. Bolen, MD, has been appointed a Scientific Grants Administrator in the Special Programs Branch of the National Heart and Lung Institute's Extramural Research Program. Dr. Bolen will be responsible for advising research grant applicants and recipients and for administering NHLI grants for the support of research in various fields.

* * *

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INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

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WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect, hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence; increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis, blurring of vision, reversible dilatation of the urinary tract, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme Division of Merck & Co., Inc., West Point, Pa. 19486.

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IMPORTANT NEWS

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SEPTEMBER 15-19, 1971

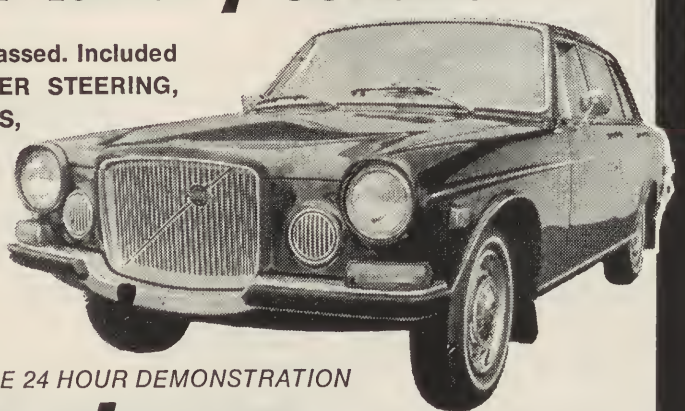
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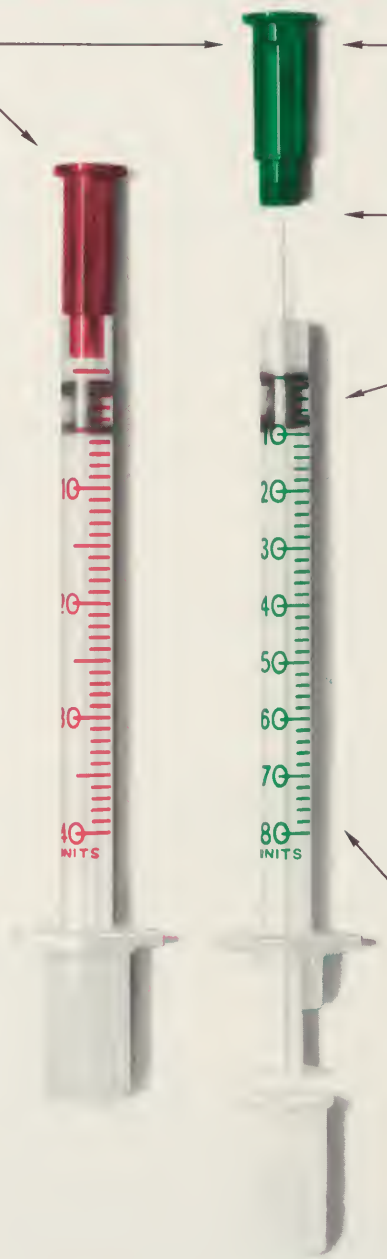
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THE MONTH IN WASHINGTON

The Nixon Administration is drafting legislation that would eliminate the reason for physicians forming professional corporations for federal income tax advantages.

The legislation would remove the tax discrimination against self-employed physicians and other professionals in the tax treatment of retirement savings.

K. Martin Worthy, chief counsel of the Internal Revenue Service, said that the legislation probably will be submitted to Congress next year as an administration measure. He said that the administration intends to "remove the present discrimination between tax treatment of qualified plans for employees and qualified plans adopted by self-employed persons."

The IRS official said that it was unfortunate that disparate tax treatment of corporate employees and professionals has led to the adoption of state laws permitting the formation of professional corporations.

"The potential, if not actual, erosion of the traditional stringent professional standards and liabilities on the part of those who form such organizations is, in my opinion, a highly undesirable by-product of this problem and its resolution to date," he told a meeting of lawyers. "The intervention of a legal entity between the doctor, lawyer, or accountant and his client would not appear to serve any social or public purposes."

Worthy warned that recognition of a professional organization as a corporation for tax purposes did not necessarily mean that the organization and its employees would have a clear track as far as securing the tax benefits which are desired.

Worthy said that an important consideration to be weighed by the professional person is that the new tax act provides for a 50% maximum tax rate, after a transition period, upon "earned income", which includes earnings from personal services.

"In view of this new tax ceiling, it is questionable whether a professional person would find it as important as it was previously to achieve the tax deferral available as an employee covered by a qualified pension or profit sharing plan," he said.

* * *

The Board of Medicine of the National Academy of Sciences urged wide use of three types of physician's assistants as the quickest way to relieve the national shortage of physicians.

In a special report, the board called for the cooperation of the American Medical Association, the Association of American Medical Colleges, and the government in developing physician's assistants programs.

The AMA has been advocating use of physician's assistants for some time. Walter C. Bornemeier, MD, President of the AMA, recently said:

"We of the AMA believe the shortage (of physicians) can be dramatically relieved if the physician divests himself of functions which can be performed by assistants or associates. That relief would be provided, not in ten years, but as fast as assistants could be trained—no major legislation, no huge appropriations of money are required. We are certain the plan will result in better care for more people at a lower unit cost. Much of the training given to the assistants is, and would be in future programs, on-the-job instruction in the doctor's office.

"There is nothing revolutionary about this plan. Until 50 years ago, American doctors trained by working in the offices of established physicians. And even with the rise of university-affiliated medical colleges, we doctors continued to train the bulk of our nonprofessional nurses and office technicians."

The NAS board said that physician's assistants could "extend the arms, legs and brains of the physician" by performing tasks that do not require the unique talents of the physician.

The three types of assistants recommended by the board were:

1) Physician's associate (the most highly-trained type) —would be qualified to do work that involves some independent medical judgment. Under the physician's supervision, he could, in some cases, make a diagnosis and perform therapy, with the range of his responsibilities increasing as he develops new skills on the job.

2) Specialized assistant— would be highly skilled in one type of clinical specialty or procedure within a specialty (such as the operation of a renal dialysis unit). He would

receive most of his training from a physician specialist.

3) Nonspecialized assistant —would be to medicine what the practical nurse is to nursing. He could receive much of his training on the job.

As the AMA has been doing, the board cautioned against the premature enactment of licensing laws that would establish rigid job qualifications before the full potential usefulness of the assistants had been determined. The board report recommended a system of registration that would permit physicians to employ assistants who had completed an approved program or otherwise established their qualifications.

Possession of a high school diploma should be an adequate prerequisite for training to become physician's assistants, according to the NAS Board. It suggested varying amounts of education, clinical experience, and on-the-job training for the three types of assistants. For physician's associates, it recommended the equivalent of two years of professional-level classroom and clinical work. Instruction should cover the basic sciences underlying medical practice, and clinical training should be "of essentially the same type and degree as that given medical students". Medical corpsmen, about 30,000 of whom are discharged from the military services each year, and other medical workers who enter the training program should be allowed credit for the clinical knowledge they already have acquired.

* * *

The American Medical Association opposed establishment of a national formulary that could restrict the prescribing practices of physicians with respect to federally-supported medical programs.

Of a letter from Sen. Russell B. Long (D., La.), chairman of the Senate Finance Committee, which was considering such legislation, Ernest B. Howard, MD, executive vice-president of the AMA, said:

"The American Medical Association, representing approximately 180,000 active private practitioners of medicine in America, is opposed to a proposal that would interfere with the professional judgment and responsibilities of physicians. The proposed amendment, which would give a Federal Formulary Committee the authority to *exclude* from the Formulary (and therefore from payment) any drug which it considers unnecessary is, in our opinion, just such an infringement upon the professional judgment of practicing physicians.

"The amendment would provide the Formulary Committee with authority to publish prescribing information about each drug listed. Adequate prescribing information to assist physicians in selecting the most rational course of therapy is available through a variety of acceptable sources. The proposed additional information is not only unnecessary but undesirable since physicians would be unable to deviate from that standard regardless of a particular patient's circumstances without facing the risk of malpractice liability.

"Further, the amendment would require that a physician who desires to prescribe the product of a particular manufacturer with which he had experience and confidence could do so only by writing in his own handwriting the established name of the drug again and the name of the preferred manufacturer. We disagree with this practice limiting the authority of the physician to prescribe the drug of his choice. Our governing body, the AMA House of Delegates, has stated and reaffirmed on many occasions that physicians should be free to use either the generic (established) or brand name in writing prescriptions.

"In addition, the proposed amendment would have the Formulary Committee institute inspections, sample examinations, and scientific review of drug products to be listed by the name of the supplier or the brand name. This task of the committee seems to be beyond its capability, particularly since it is constituted only on a part-time basis . . .

"We have said many times that we want our patients to receive high-quality drugs at the lowest possible cost. We continue in this position, more strongly than ever. But, we firmly believe that the creation of a national formulary would not bring about a more economical provision of drugs under programs established within the Department of Health, Education, and Welfare, nor would it enhance the quality of these drugs."

* * *

The American Medical Association supported a Senate-approved bill that would expand federal family planning services and population research activities.

In a statement submitted to the House Subcommittee on Public Health and Welfare, the AMA said it believes the establishment of an Office of Population Affairs under a deputy assistant secretary in the Department of Health, Education, and Welfare is highly desirable. The office would make formula or special project grants relating to population and family planning; administer population and family planning research; act as a clearinghouse on domestic and international population family planning programs; provide liaison with other federal agencies; and support training for manpower in these programs.

The bill (S. 2108) also would authorize special projects for family planning services, formula grants for family planning, training and research grants, and grants for the construction and operation of population research centers.

The AMA said that there is an urgent need for a greatly expanded program of population research, as authorized by the legislation.

"If the worldwide population increase is to be controlled," the AMA said, "it will require more scientific knowledge of human behavior. We need more research on reproductive physiology, more demographic research, and more attitudinal and motivational research."

The AMA listed a number of obstacles to be overcome if a national program for population control is to be effective: education, religion, legal, and economic considerations.

"The most formidable of these is lack of education," the AMA statement said. "Population control is only attainable when people first understand the nature of their own bodies."

Meantime, the Defense Department disclosed that a series of rulings this year had made it mandatory that U.S. military base hospitals throughout the world perform abortions and surgical sterilizations for armed forces personnel and their dependents regardless of state and local laws.

Dr. Louis M. Rousselot, Assistant Secretary of Defense for Health and Environment, issued the rulings to clarify a policy that had been effective since 1966 but which some bases had not been following.

* * *

Five Republican senators introduced legislation that would establish a four-year federal program of family physician scholarships and fellowships to medical students and graduates who agree to practice in physician-shortage areas or to serve migratory agricultural workers.

For the first year, about 500 scholarships not to exceed $5,000, and 200 fellowships would be offered at a cost of $4.5 billion. The program would be expanded each year until, by the fourth year, 1,000 scholarships and 500 fellowships would be authorized for students and graduates agreeing to practice in isolated rural areas, migrant areas, city ghettos, and Indian reservations with a shortage of physicians.

For each year of a scholarship, one year of service would be required. No additional service would be required under the fellowship part of the program.

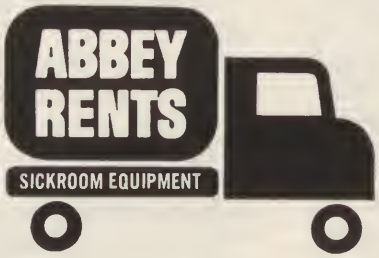
Sen. George W. Murphy (R., Calif.) was chief sponsor of the legislation (S. 4208). Cosponsors were Sens. Peter H. Dominick (R., Colo.), Jacob K. Javits (R., N.Y.), Winston L. Prouty (R., Vt.), and William B. Saxbe (R., Ohio).

* * *

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Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

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Doctors Take Note . . .

(Continued from page 14)

NOVEMBER 2-6, 1970
AMERICAN ASSOCIATION FOR LABORATORY ANIMAL SCIENCE

21st Annual Session: Conrad Hilton Hotel, Chicago, Illinois. Contact: Joseph J. Garvey, Executive Secretary, American Association for Laboratory Animal Science, 4 E. Clinton St., Box 10, Joliet, Illinois 60434.

NOVEMBER 4-7, 1970
AMERICAN SOCIETY OF CYTOLOGY

18th Annual Scientific Meeting: Biltmore Hotel, Los Angeles, California. Contact: Warren R. Lang, MD, Secretary-Treasurer, 7112 Lincoln Drive, Philadelphia, Pennsylvania 19119.

NOVEMBER 6-8, 1970
CONGRESS OF COUNTY MEDICAL SOCIETIES

Annual Meeting: Netherland Hilton Hotel, Cincinnati, Ohio. Contact: Joseph Boyle, MD, Congress of County Medical Societies, P.O. Box 54571, Terminal Annex, Los Angeles, Calif. 90054.

NOVEMBER 6-8, 1970
ASSOCIATION OF CLINICAL SCIENTISTS

Fall Meeting: Shoreham Hotel, Washington, D.C. Write: F. W. Sunderman, University of Connecticut School of Medicine, Hartford, Conn. 06112.

NOVEMBER 6-19, 1970
GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

Postgraduate Medical Seminar Cruise: The Caribbean. Contact: Allen Travel Service, 565 Fifth Ave., New York, N.Y. 10017.

NOVEMBER 7-11, 1970
AMERICAN SOCIETY OF CYTOLOGY

Reconvened Scientific Meeting: Surfrider Hotel, Waikiki Beach, Honolulu, Hawaii. Contact: Foothill/ Conventionaire Travel Service, Inc., 8346 Foothill Boulevard, Sunland, California 91040.

NOVEMBER 9-13, NOVEMBER 16-20, 1970
CHICAGO MEDICAL SOCIETY

Two Postgraduate Courses—Internal Medicine, Obstetrics and Gynecology: Knickerbocker Hotel, Chicago, Illinois. Each course lasts one week and costs $150. Thirty-two and one half hours of credit approved by the Academy of General Practice can be earned from each course. Contact: Chicago Medical Society, 310 South Michigan, Chicago, Illinois 60604.

NOVEMBER 9-20, 1970
DEPARTMENT OF OTOLARYNGOLOGY, COLLEGE OF MEDICINE, UNIVERSITY OF ILLINOIS

Postgraduate Course—Laryngology and Bronchoesophagology: Eye and Ear Infirmary, University of Illinois Hospital, 1855 West Taylor Street, Chicago, Ill. The course is limited to 15 physicians and will include visits to several other Chicago hospitals. Write: Paul H. Holinger, MD, Department of Otolaryngology, Abraham Lincoln School of Medicine of the College of Medicine, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

NOVEMBER 10-15, 1970
AMERICAN HEART ASSOCIATION

Annual Meeting: Atlantic City, New Jersey. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201.

NOVEMBER 11-12, 1970
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Conference—Biological and Psychological Facts in the Area of Sex and Gender Deviations in Children and Adolescents: University of Missouri at Columbia, Missouri. Contact: Executive Director, Continuing Medical Education, M-175 Medical Center, Columbia, Missouri 65201.

NOVEMBER 11-13, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Genetics for the Internist: New York, New York. Contact: American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

NOVEMBER 11-14, 1970
MOUND PARK HOSPITAL FOUNDATION, INC.

4th Annual Postgraduate Conference: St. Petersburg, Fla. Contact: M. A. Barton, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida 33701.

NOVEMBER 12, 1970
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE/REGIONAL MEDICAL PROGRAM

Postgraduate Course—Current Advances in Cerebral Vascular Disease: University of Maryland, Baltimore, Md. Contact: The Committee on Continuing Medical Education of the University of Maryland, 522 West Lombard St., Baltimore, Maryland 21201.

NOVEMBER 13-14, 1970
DEPARTMENT OF OTOLARYNGOLOGY, UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

Postgraduate Course—Otolaryngology for the Family Practitioner: Sheraton Four Ambassadors Hotel, Miami, Fla. The course is accredited by the AAGP. For information, write: Frederic W. Pullen, II, MD, Neuro-Otologic Laboratory, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

NOVEMBER 15-19, 1970
ACADEMY OF PSYCHOSOMATIC MEDICINE

17th Annual Meeting—Treating Emotional Illness: Bermuda. Contact: Edwin Dunlap, MD, Executive Secretary, 150 Emory Street, Attleboro, Massachusetts 02703.

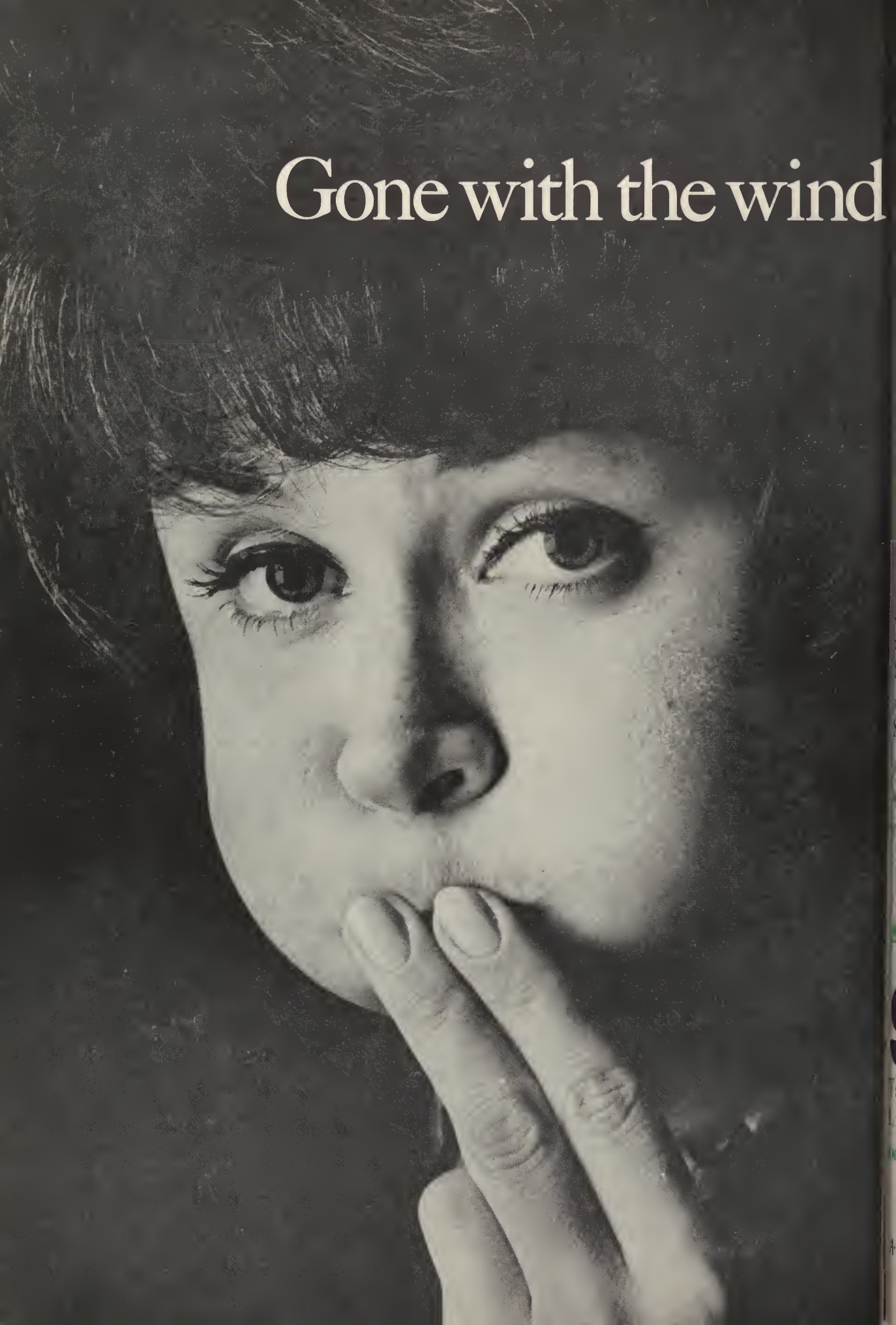
NOVEMBER 15-19, 1970
PENNSYLVANIA MEDICAL SOCIETY

Annual Scientific Assembly: Host Farm Resort Motel, Lancaster, Pennsylvania. Contact: Pennsylvania Medical Society, 20 Erford Road, Lemoyne, Pennsylvania 17043.

NOVEMBER 16-19, 1970
SOUTHERN MEDICAL ASSOCIATION

64th Annual Meeting: Dallas, Texas. Contact: Southern Medical Association, 2601 Highland Avenue, Birmingham, Alabama.

(Continued on page 45)


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*Hanger, A.: Med. Times 94:150 (Feb.) 1966.

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Doctors Take Note . . .

(Continued from page 41)

NOVEMBER 19, 1970
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Renal Disease, Diagnosis and Management: University of Maryland, Baltimore, Md. Contact: The Committee on Continuing Medical Education, 522 West Lombard St., Baltimore, Md. 21201.

NOVEMBER 19-20, 1970
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

Seminar in Obstetrics and Gynecology: College of Medicine, University of Florida, Gainesville, Fla. Contact: Division of Postgraduate Education, J. Hillis Miller Health Center, Box 758, College of Medicine, Gainesville, Fla. 32601.

NOVEMBER 20-22, 1970
AMERICAN COLLEGE OF PHYSICIANS

Four-State Regional Meeting—Delaware, District of Columbia, Maryland, and Virginia: Williamsburg, Virginia. Contact: Harry F. Klinefelter, MD, 550 North Broadway, Baltimore, Maryland 21205.

NOVEMBER 27-28, 1970
DEPARTMENT OF OTOLARYNGOLOGY, UNIVERSITY OF ILLINOIS

Course—Conference on Radiology in Otolaryngology and Ophthalmology: University of Illinois Hospital, Chicago, Illinois. For additional information, write: Professor Valvassori, Radiology Department, College of Medicine, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Illinois 60680.

DECEMBER 2, 1970-FEBRUARY 24, 1971
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Review in Family Practice: University of Maryland School of Medicine, Baltimore, Maryland. Fee: $50; 22 hours of credit may be earned. Contact: University of Maryland School of Medicine, Committee on Continuing Medical Education, Baltimore, Maryland 21201.

FEBRUARY 27-28, 1970
AMERICAN BOARD OF FAMILY PRACTICE, INC.

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THE HISTORY OF CARDIAC SURGERY 1896-1955, Stephen L. Johnson, MD; The Johns Hopkins Press, Baltimore, Maryland, 1970.

Cardiac surgery began in 1896 with Ludwig Rehn's first successful suture of a human heart. This book traces the history of this field of surgery up to 1955. Even though open heart surgery is, of course, the most dramatic procedure mentioned in this publication, other techniques and instruments are handily described.

What makes this book intensely interesting is the first person contact that Doctor Johnson had with many of the pioneers in this field. Details of what actually happened were obtained from such persons as Doctors Harkin, Bailey, Taussing, Hufnagel, Gibbon, Lillehi, and others.

This book is not written in the stilted, medical prose that so often characterizes medical publications. It is worthwhile reading not only for its scientific history and facts, but because it is almost as good as a novel.

HANDBOOK OF LEGAL MEDICINE, Alan R. Moritz and R. Crawford Morris; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This book serves as a concise reference for both law and medical students. It provides specific answers to specific medicolegal questions. Now in its third edition, this publication is divided into three main sections: Scientific Medicolegal Investigation; Physician and Patient—Physician and the Law; and a Glossary of Terms.

While it is a condensed volume, it is thorough. It offers fundamental, practical, and timely information to the reader.

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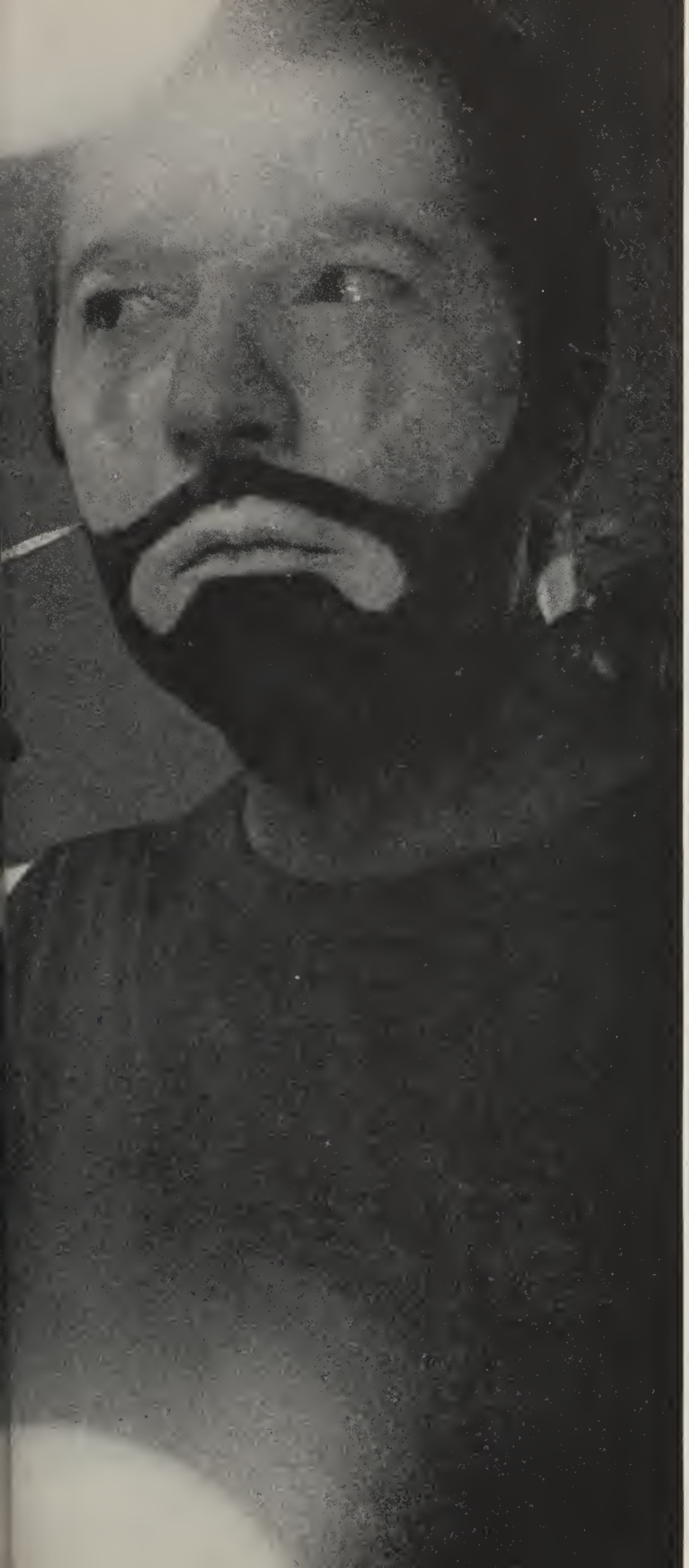
Pro-Banthine 15 mg. propantheline bromide

Pro-Banthine 15 mg. propantheline bromide with Dartal 5 mg. thiopropazate dihydrochloride

Pro-Banthine 15 mg. propantheline bromide with Phenobarbital 15 mg. warning: may be habit forming

Pro-Banthine P.A. 30 mg. propantheline bromide in time-release form

Pro-Banthine 7½ mg. propantheline bromide Half Strength



Pro·Banthine®
(propantheline bromide)

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Dartal® 5 mg.
(thiopropazate dihydrochloride)

Indications: Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthine with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro-Banthine® 15 mg.
(propantheline bromide)
with
Phenobarbital 15 mg.

Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

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Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatme of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of t upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elder patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 m

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliati dermatitis; photosensitivity; onycholysis, n discoloration. *Kidney*—dose-related rise BUN. *Hypersensitivity reactions*—urticar angioneurotic edema, anaphylaxis. *Intracran* —bulging fontanels in young infants. *Teet* yellow-brown staining; enamel hypoplas *Blood*—anemia, thrombocytopenic purpu neutropenia, eosinophilia. *Liver*—cholestasis high dosage.

Upon adverse reaction, stop medication a treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

5

Cerebral Training

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Cerebral training constitutes a very highly structured, massively standardized regimen that makes use of neurophysiologic principles rather than psychiatric concepts—cerebral mechanisms instead of mental dynamisms. It is a nonmedicinal, controlled, methodic, organized, sustained training program which concerns itself with the systematic and orderly cultivation of continuing and progressive self-potentiated self-development.

In this article, cerebral training is presented in a manner designed to appeal to a broad scientific audience. Its interest value is both general and interdisciplinary. The methodologic technic employed has wide significance as well as extensive utility.

There are 60 applications for cerebral training. It may be used in treating alcoholism, cancer, drug addiction, or organic disease, or in programs with delinquents, parolees, prisoners, school dropouts, or the underprivileged. Cerebral training may also be used in community health centers, mental hospital wards, stroke centers, and training schools. It may also be used for youth programs or physical rehabilitation, prevention, or manpower development programs.

Cerebral training is easy from three standpoints. First, it is easy for trainees to learn and apply. Second, it is easy for institutions to include and employ. Finally, it is easy for instructors to acquire and impart.

Class Instruction Period

With cerebral training, the medical model has been abandoned and the educational approach adopted. The physical setup of each **class instruction period** in cerebral training is more academic than therapeutic. During each instruction period, I am a teacher and a trainer, not a theorist or therapist. My approach is not that of the physician. Instead, it is one of an instructor.

The people who come for help are not patients. They are trainees. They are not sick. They merely have an unnecessary degree of cerebral disorganization. We do not use group therapy techniques; we have class instruction periods. We adopt the view that very many disorders and derangements have been learned which, in turn, can be unlearned. Therefore, during the training sessions, continuous attention is paid to the mechanics involved in learning, unlearning, relearning, and overlearning.

Each class instruction period consists of three parts. At the beginning of each part, the instructor goes through the **chalkboard routine.** This consists of writing five items on the chalkboard: Do not think negative thoughts! Do not waste your time! Review! Reflect! Resolve!

Part I of each class instruction period is the **auditing portion.** This consists of listening to a tape-recorded interview that I have made with an advanced trainee. This trainee professes to have learned, with telling effectiveness, to apply the various principles of cerebral training to himself, to his symptoms, to his problems, and for his development.

During the auditing portion, the trainees listen to the many benefits and learn of the many technics from the tape-recorded interviews. Whenever an outstanding achievement or a remarkable attainment is described, the members of the class silently think to themselves: "If *he* can do it, *I* can do it! If *he* can do it, *I* can do it! If *he* can do it, *I* can do it!" or, "If *she* can do it, *I* can do it!" This perseveration is vigorously continued throughout the time the advanced trainee on the tape-recorded interview is describing his accomplishments.

Part II of each class instruction period is the **cogitating portion.** It has three subdivisions: **review, reflect, resolve.** These are periods of silence. For one minute the trainees review their past constructively; for two minutes they reflect over their present wholesomely; and for three minutes they resolve about their future decisively. Appropriate instructions and directions as to what to do and how to do it are issued repeatedly by the instructor.

Part III of each class instruction period is the **achievement portion.** Under the controlling aegis of the instructor, information is educed from one trainee after another for the benefit of their classmates. Each trainee talks about his achievements and just how he went about making them.

There are over 235 tape-recorded interviews that have been made. Their playing time ranges from 12 minutes to 20 minutes. The first recordings were

made in 1946. Over the years, they have provided a library of extraordinarily diverse diseases and disorders. The settings under which they were made have been quite varied: a Veterans Administration hospital; a state training school for boys; an alcoholism division of a hospital; a community college; a group practice clinic; and in a private practice session.

The **reinforcement period** is one of the sessions which takes place outside the class instruction period. During the reinforcement period, each trainee is encouraged to talk to a partner or to a small group of fellow trainees. From time to time throughout the day and evening, for about 30 seconds at a time, each trainee is to tell his classmates just how he plans to continue to practice cerebral training for himself and with his family after he returns home and reenters the community.

Practice Procedures

The practice procedures employed by the trainees include **cerebral exercises** which constitute self-instructions. These take the form of simple phrases which are usually repeated silently.

Flashback consists of recalling the congenial surroundings of practice sessions and past experiences at the time of a possible imminent disagreeable encounter.

Action sessions consist of acting out before a full-length mirror, with an exaggerated degree of confidence and success, certain anticipated settings and situations of the future.

The principle of **project into the future** consists of the effective concurrent combination of an appropriate cerebral exercise and a suitable visual image.

Visual images consist of both reality and fantasy constructions of a strongly positive and highly successful nature.

The fifth paragraph of the instructional procedure titled **Saturday Morning Routine** reads: "So every Saturday morning while you are dressing, remember to pull out this Symptom List and reread it. As you contemplate your steady improvement regarding them (that is, your symptoms) you will experience, progressively, the deep satisfaction and the glow of success felt by those trainees who came before you."

The list of handouts comprises a four-page itemization of materials. The handouts in cerebral training are issued under the general headings of **informational set, operational set,** and **procedural set**. The informational set is subdivided into groupings for the sophisticated specialist, the interested professional, and the intelligent layman. The operational set has two subdivisions—preliminary and ongoing. Both are for persons who take the course itself. The procedural set provides the materials for the instructor when he conducts the class.

Among other things, each trainee is issued a coil-spring notebook and pencil. He is enjoined, in a stipulated manner, to make certain entries in a specified fashion.

There are 30 training manuals which have been written for each trainee. The sixth in the series, for example, is entitled "Class Instruction #2". The 17th in the series is "Your Proper Use of Visual Images". The 23rd is "The Patient Makes Himself Well #4". And the 29th is "Cerebral Exercise #10".

The largest number of trainees which have been instructed in a class instruction period is 164. Contrary to the registered expectations of many persons, the larger the classes, the better the results may be.

The Instructor

Let us assume for the purpose of argument that cerebral training compares favorably with any other method of its kind, anywhere. If this were true, the potential value would be reduced appreciably if its innovator were the only one who could use it. Accordingly, literally hundreds of hours have been spent in writing the information in a style which is direct, simple, and clear, so that selected individuals can become effective instructors in just a few hours.

It is easy to become an effective instructor in cerebral training. This is true principally when one considers all the things it is not necessary to do. For instance, it is not necessary to spend years in arduous preparation, nor to have several advanced degrees, nor to undergo special training. It is not necessary to take long series of extensive study courses, nor to assimilate mounds of technologic information, nor to go through months of difficult practice sessions under highpowered supervision.

There are 22 categories of personnel listed on the card titled **potential instructors**. These range from alcoholism counselors through teachers.

Assume we have selected a promising candidate from one of the 22 groups on the register of potential instructors. What is available to this candidate to facilitate his period of training? For one thing, there is an **instructor's guide**. Whereas the guide contains 24 chapters, these comprise only 132 pages. It is desirable but not essential that the aspiring instructor read this guide.

Instructor's Cards

Suppose our potential instructor has not read the instructor's guide. Assume the time has arrived when he finds himself standing before a class of 100 or more trainees, with 90 minutes to fill from the time he greets them with a cheery "Good morning!" to the time he closes with a crisp "Class dismissed!" What should he do, and how does he do it? What

should he say and how does he say it? The answers to these questions are available to him on six sets of **instructor's large cards.**

Each set takes care of an entire class instruction period. There are from 16 to 18 cards in each set. They tell him exactly what he must do and how he should do it, as well as what he should say and how he should say it, each step of the way, from the moment that he begins the class instruction period up to the time that he terminates it.

Certain topics should be brought out and certain questions should be raised during the achievement period. But what are the topics? And what are the questions? Once again the instructor's life is made easier because the topics to be covered and the questions to be asked have been written out for him. They appear on the ten **instructor's small cards.** Each of them covers an entire achievement period. These ten **topic cards** are titled **arthritis, automatics, cerebral exercises, main symptom or trait, manuals, pain, single achievement, skepticism, sleep,** and **visual images.**

So, in essence, it may be stated that the principal ingredient for a suitable applicant to be an effective instructor in cerebral training is that he be a good reader.

Future plans call for continuing revaluation of this method, especially for improvements and refinements. They also call for an attempt to reduce the disparity between the profusion of those who sorely need help, and the paucity of those who can capably deliver it. The basis for selection of instructors in cerebral training will be determined less by degrees awarded and honors conferred in the past, than by competence demonstrated and qualities possessed at the time of selection. This training program will make it possible for people with little or no extraordinary training to bring about modification of behavior which compares very favorably with that reported by the rank and file professionals.

Those more sophisticated workers whose life styles are not too rigid or those who do not feel easily threatened, those who have a zest for life, those who enjoy taking calculated risks, and those who are sufficiently interested will also be warmly welcomed.

Research Supporting Cerebral Training

John W. Gardner,[1] President of the Carnegie Foundation and a past Secretary of HEW, has written, "The most hopeful thing today is that on *some fronts* we seem to be achieving patterns of organization that avoid the stultification, rigidity, and threats to freedom inherent in monolithic integrations. If this is true, it may be the most important single fact in our future."

I have been repeatedly astonished by the vigorous insistence made in writing and in speech by behavioralists who contend that the ingenuity of the therapist is sorely taxed in developing an hierarchical series of graduated progressions to desensitize the patient with minimal discomfort. The reason for my astonishment stems from the fact that I have found it not at all necessary to tax my ingenuity with such strenuous demands. I simply instruct my trainees in a brief and general way in the mechanics and procedures.

For example, they concentrate on the image of seeing themselves unafraid in a phobic situation. At the same time, they repeat to themselves silently and fixedly the cerebral exercise, "I'm *not* afraid, I'm *not* afraid, I'm *not* afraid, I'm *not* afraid."

The first sentence on one handout reads: "The symptoms listed below are representative of those from which trainees have learned to free themselves." Then follows an inventory of 122 symptoms ranging from aching feet to weak erection, and from always tired to worried.

Miller [2] has commented on the strength of the belief that instrumental learning of glandular and visceral responses is impossible. He feels that it is only against a cultural background of great prejudice that such weak evidence as exists could lead to such strong convictions as prevail. He reports a considerable degree of success in bringing about the learning of visceral and glandular responses. From his work on animals, he conjectures that if patients are aware that they can secure some control of their symptoms, this will provide strengthened motivation in that direction. He feels that this principle and the technic for bringing it about would have application in the field of clinical medicine. He gives such examples as cardiac arrhythmias, spastic colitis, asthma, and certain forms of vascular hypertension.

Shapiro, et al,[3] present impressive data with respect to the effects of feedback and reinforcement on the control of human systolic blood pressure.

Fetz [4] has written on the operant conditioning of the activity of single neurons in the precentral cortex of unanesthetized monkeys. To those who are unfamiliar with these developments, it should seem plausible that if so delicate and small a structure as a single neuron can be influenced in that manner, surely the same principles should pertain in such gross structures as the heart, blood vessels, and stomach. That such indeed is the case has also been recorded by Kimmel,[5] as well as by Katkin and Murray.[6]

At one point in its development, cerebral training was put into operation for two years in a large hospital. Among the largely unmotivated semi-deteriorated and semi-dilapidated schizophrenics and those with chronic brain syndromes, there were one or more of the following clinical entities: lobotomies, epilepsy, alcoholism, cerebellar atrophy, paralysis agitans, choreiform movements, ruptured interverte-

bral disc, arthritis, spinal fusion, phantom limb, amputation ulcers of the foot, cirrhosis of the liver, stroke, intermittent claudication, Addison's disease, cervical metal brace, diabetes, angina, and cancer.

The patients suffering from that heterogeneous group of afflictions met five mornings a week for 1½ hours. Such manifest conditions as paralysis agitans, cirrhosis of the liver, stroke, Addison's disease, diabetes, and cancer can only be treated at a symptomatic level with cerebral training. However, for these conditions and for other diseases and disorders, symptomatic amelioration is at times remarkable, and for some disturbances may be complete.

The circumstances of a trainee's disorder and the setting of the operation determine the frequency of the classes. Minimally, they are held once a week. For an outpatient clinic or in a community health center, the optimal number would be twice a week. In all instances, the class instruction periods last 90 minutes.

Prevention

Because he has already succeeded in learning how to overcome large problems in his course in cerebral training, it becomes easy for the trainee to cope with small ones when he returns home. He has learned how to keep little ones from becoming big ones. By simply applying the very same principles he has used successfully in overcoming his ailment, he immediately quashes the slightest and the earliest sign of its reappearance. If a trainee can regain normalcy through cerebral training when he is weak, then surely it will be possible for him to prevent the recurrence of his particular affliction through cerebral training when he is strong.

Furthermore, by using the various principles with modification of some of the technics, there is much reason to believe that the advanced trainee can prevent the occurrence of other diseases, disorders, disabilities, and derangements that may affect him later.

Success of the Program

So far, the results of this program have been gratifying, although the measures employed are incomplete and subject to error. They consist of observations by the instructor, attestations by the trainees, affirmations by hospital personnel, and confirmations by relatives, employers, and public health nurses.

The trainees report gratifying degrees of success and in much less time than is given in many accounts I read and hear about. Manifestly, the behavior of unsophisticated patients can be determined by a highly-charged attitude of expectancy.

That the results of this method should be subjected to scientific validation afforded by rigorous experimental design with proper controls, randomization, independent scorers, uninformed evaluators, etc, is incontestable. Meanwhile, it is felt that the claims made should be received with no more and no less reservation than that which is accorded the ordinary pilot study or demonstration project.

Berkson,[7] Cartwright,[8] Glover,[9] Goldstein,[10] Mainland,[11] Mowrer,[12] and Schor,[13] are among those luminaries who have indicated that many, if not most experimental designs are constructed so poorly that they are meaningless or even worthless. Controls are inadequate, randomization is lacking, and the statistical treatment is improper. Up to the present time, circumstances have not been favorable for the development of a tightly-knit experimental design involving cerebral training. Conditions have been sufficiently adverse as to preclude an outcome research study in terms of effects that could be measured accurately and reliably. Therefore, I have chosen no design, rather than a poor one.

It has been possible to make this approach available in the form of a **package program.** All the essential ingredients have been incorporated as a self-contained unit. It includes tape recorders, cassettes of tape-recorded interviews, a stopwatch, manuals, notebooks and pencils, and the instructor's paraphernalia. This package is available now in a serviceable form and is ready for delivery anywhere.

Summary

1. Cerebral training is a self-help training program for self-potentiated self-development.
2. It is easy to learn and easy to apply.
3. It uses the educational approach.
4. Trainees participate actively in the process of contributing substantially to their own progress.
5. Each trainee receives 30 training manuals which contain supplemental instructions and injunctions.
6. Selected persons can become effective instructors in a few hours.
7. Multifarious conditions can be dealt with concurrently, and with large groups at the same time.
8. Technics for preventing recurrence of the same condition or development of new ones are built into the operation.
9. The program can be packaged and delivered to needy areas.

REFERENCES

1. Gardner, J. W.: *Self-Renewal,* New York: Harper & Row, 1963, p. 63.
2. Miller, N. E.: *Science* **163:**434-445, 1969.
3. Shapiro, D., et al: *Science* **163:**588-589, 1969.
4. Fetz, E. E.: *Science* **163:**955-957, 1969.
5. Kimmel, H. D.: *Psychol Bull* **67:**337, 1967.
6. Katkin, E. S., and Murray, E. N.: *Psychol Bull* **70:**52, 1968.
7. Berkson, J.: *JAMA* **172:**967-969, 1960.
8. Cartwright, D. S.: *J Counseling Psychol* **2:**290-295, 1955.
9. Glover, E.: *International J Psychoanal* **33:** 272, 1952.
10. Goldstein, A. P.: *Therapist-Patient Expectancies in Psychotherapy,* New York: Macmillan, 1962, p. 85.
11. Mainland, D.: *Elementary Statistics,* Philadelphia: W. B. Saunders, 1963, p. 4.
12. Mowrer, C. H.: *Psychotherapy: Theory and Research,* New York: Ronald Press, 1953, p. 271.
13. Schor, S. S.: *JAMA* **196:**12, 1966.

In the absence of clear neurological signs, the recognition of brain disease may be uncertain. This fact applies particularly to those cases in which the specific mental changes indicative of brain disease are not obviously present, but are masked by the signs of emotional disturbances, usually not associated with cerebral pathology.

Neurological States Masquerading As Psychoses

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Depressive, paranoid, manic, and catatonic reactions, approximately in this order of frequency, may be present in association with impairment of cerebral functions. Hysteric or obsessive-compulsive reactions have also been observed imbedded in the course of a brain disease.[1]

Any of the well-known mental disturbances may be part of a brain syndrome. The disturbances are often fleeting and variable in their occurrence but, at times, persistent. Occasionally, they may last far beyond the estimated impact of the noxious factor.

Marked anxiety is very frequently found in patients with acute cerebral impairment and often is a reaction to the frightening deficit. In contrast, the majority of the cited emotional disturbances, with their typically unpredictable course, probably have to be understood as the direct result of cerebral irritation. For diagnostic purposes, all these emotional disturbances have to be clearly differentiated from those mental traits which invariably are associated with cerebral impairment. Various authors have proposed different terms for the two sets of mental changes, as noted in Table 1.

The terms "organic" and "functional" represent a false dichotomy and should not be used. S. Cobb,[2] among many others, has pointed out that function cannot be thought of without some degree of structural change. The term functional refers to the performance aspects of certain structures. While neurologists correctly refer to idiopathic epilepsy as a functional disorder of the central nervous system, this same illness is considered an organic condition in psychiatry. Much confusion could be avoided by adherence to the correct use of the terms.

Romano and Engel's [3, 4] terminology of primary and secondary mental signs of cerebral impairment appears to be well chosen and will be used here. Table 2 contains the primary signs as they are reported in the literature.[5-7]

Table 1: Terminology For the Two Sets of Mental Changes Observed in Cerebral Impairment

Specific for Cerebral Impairment	Not Specific for Cerebral Impairment	Author
exogenous	endogenous	Bonhoeffer
obligatory or basic	optional or accessory	Stertz
heteronomous	homonomous	Kleist
symptomatic	genuine	Küppers
primary	secondary	Romano & Engel

Table 2: The Primary Mental Signs of Cerebral Impairment

Signs	Manifestations
1. "clouding of consciousness" (defect signs)	impairment of: attention * coherent thinking * memory * orientation; especially characteristic is the slowness and easy fatigability of intellectual performance
2. release of lower-level mental activities (productive signs)	hypnagogic reveries, disquieting dreams, dream-like experience while awake, delusions, hallucinations, and illusions
3. defective attempts at intellectual readjustment	circumstantiality * perseveration * confabulation suggestibility
4. characteristic affective response	affective lability: * rapid shifts from tears to laughter, from anxiety to anger
5. disturbance of the wake-sleep regulation	insomnia or somnolence

* signs that remain in the chronic cerebral impairments

The basic mental status examination given to all the patients is outlined in Table 3. All patients studied, with the exception of Case 4, were seen on several occasions. The interviews lasted longer than one hour if it appeared important to get an estimate of the effect of fatigue on the patient's performance. Care was given to insure the best possible cooperation from the patient during the examination. In all

patients, again with the exception of Case 4, a close relative was interviewed in order to get an estimate of the course of the illness and of the premorbid emotional adjustment.

Table 3: Mental Status Examination

1. **Check orientation in three spheres (person, place, time).**
2. **Ask for specific events of the very recent past.**
3. **Ask for the names of the last five presidents, and five of the largest cities in the United States.**
4. **Ask the patient to remember a given address; check recall five minutes later.**
5. **Give a few calculations (vary according to premorbid intellectual level of patient).**
6. **Ask for serial subtraction of 7 from 100 (or 3 from 21).**
7. **Check ability to recall increasing numbers of digits forward and backward.**
8. **Ask for the similarity between two objects (eg, bird and bee, apple and tomato).**
9. **Ask for interpretation of three proverbs (chosen according to premorbid intellectual level of patient).**
10. **Ask patient why he is in the hospital.**

The impact of a given cerebral impairment varies enormously with the premorbid make-up of the patient.[4, 8] Persons with a well-functioning mental organization compensate better for cerebral deficits than others who had premorbid psychological difficulties. It appears that the secondary signs, as the more personal aspects of behavior, vary particularly according to the premorbid personality and in relative independence from the type of noxious factor. The primary signs, on the other hand, appear to be more of an impersonal nature, varying with type and intensity of the noxious factor.[3, 4] They alone are the reliable indicators of brain damage for the psychiatrist.

Study of Five Patients

The patients studied here were referred to the neurosurgical service of The Johns Hopkins Hospital because a cerebral lesion was originally suspected. They all presented with marked emotional disturbance, at a time when only equivocal or no physical signs of a brain disease were obtained. Consequently, they were referred for psychiatric evaluation.

Case 1

K.H. was a 53-year-old man, married, and a sales manager.

History: This patient had been emotionally well adjusted and in good health until he developed a tremor of the right hand one year prior to admission. He then developed a tremor of the left hand. He became forgetful, generally slow in his reactions, and easily tired, which coincided with the time he assumed a new and more responsible job.

Psychiatric Evaluation: The patient was stiff and slow in his motions. He was friendly and cooperative, and slow and deliberate in his speech. Mental status examination revealed that he had a very poor recent memory, particularly for names. His thinking was slow and perseverative. He had a tendency to stick to insignificant concrete details (eg, the interviewer's tie). He also had difficulties in grasping new ideas. His understanding of proverbs was below the expected level. Often, he was unable to pronounce complicated words. Occasionally he was confused at night, wandering into other rooms and delivering incomprehensible messages to other patients. He was aware that he was not doing well in his new position, but his affect was not abnormal and he was free from any depressive thoughts.

Impression: He was diagnosed as suffering from marked diffuse cerebral impairment. His retardation was due to brain disease, which simulated a depressive reaction. The new demands of his more responsible position had led to the decompensation of his performance. Gross primary signs made the diagnosis easy, but true secondary signs were entirely lacking.

Follow-up: Shortly after the psychiatric examination, a pneumoencephalogram showed marked diffuse atrophy of the brain. A brain biopsy was refused. The final diagnosis was advanced cerebral arteriosclerosis. However, a presenile psychosis or a "primary atrophy" of the brain could not be ruled out.

Comment: The patient reportedly had been a stable individual before his illness. Although a marked deterioration of his performance was now present, secondary signs of brain disease were absent.

Case 2

A.G. was a 48-year-old woman, married, and an accountant.

History: This patient, the mother of five children, had been well adjusted and free from any major illness. Six months prior to admission, she left a job that she had held for one year. She complained of some trouble with her eyesight. The next job she took she lost after one week, which upset her very much. On a third job, she was happy at first, but then began to feel the boss was overly critical of her and gave her too much work. Being in no financial need, she quit this job, and then felt better. One week later, on Easter Sunday, she woke up com-

plaining of being nearly blind. She was now very upset, and cried frequently. Shortly thereafter, she was admitted to the hospital. She had been in the process of passing an examination to be licensed as a certified public accountant. She had obtained good grades on the first part of the examination, but may have felt that she was under some pressure to successfully pass the upcoming final test.

Physical Evaluation: A left hemianopsia was the only consistent neurological finding, but this was somewhat doubtful because she often complained that she could not see at all.

Psychiatric Evaluation: This patient was entirely cooperative, always anxious, and often tearful for brief spells without apparent provocation. Her memory was somewhat hazy, eg, she was not sure of her own address. On serial 7, she made two gross mistakes: when asked to repeat the series, she proceeded slowly and correctly until she was incapable of subtracting 7 from 23. She perseverated occasionally in her talk. We had clearly proceeded to talk about her second daughter, when I realized she continued to tell me about her first daughter. She abstracted poorly on proverbs. When she was asked to write down her own name, she misspelled it, using too many arches on the letter "m"—another perseverative tendency.

Impression: In the presence of a number of primary signs of cerebral impairment, the diagnosis of brain disease was made. The secondary sign, the hysterical reaction, may have been the patient's reaction to her shortcomings. The easy tears were not a sign of depression, but of the cerebral impairment.

Follow-up: A brain biopsy was negative, as is often the case. One year later, the patient still had her left hemianopsia, was less anxious, but had remained unable to return to her former level of functioning. The diagnosis of Schilder's or Pick's disease was suspected, but not further confirmed.

Comment: This patient with previously good emotional adjustment showed secondary signs (anxiety and conversion hysteria) which had, to a certain degree, masked the presence of brain disease. The few clear-cut primary signs permitted the diagnosis.

Case 3

G.D. was a 48-year-old man, married, and a missionary.

History: This patient had been free of emotional difficultics and had led a very active life. He was stationed overseas. Six weeks prior to admission, he accidentally struck his head against the opened hood of his car. This incident was recalled one week later, when his wife began to notice that he had lost his usual zest and would often repeat himself. Again, a few days later, he complained of confusion. He had a headache and vomited on the following day, then spent three days in bed. He felt very depressed and stated that, for the first time in his life, he could understand why people committed suicide. He belittled his complaints and repeatedly refused medical help. When he finally submitted to a medical examination, he was advised to fly home and enter a hospital. The report of the referring physician stated that the patient was alert, but disoriented as to time, and that he tended to lose the thread of a conversation. A loss of distinctness of the disc margins was also noted.

Physical Evaluation: A complete work-up for brain disease was negative. No significant abnormality of the fundi of the eyes was found. The reported injury to the head was felt to be insignificant. A conglomeration of abnormal blood vessels on cerebral arteriography could be interpreted as a harmless malformation. In view of the marked depression, he was referred for psychiatric evaluation.

Psychiatric Evaluation: The patient was very cooperative and tried to be cheerful. He did not remember the names of any of his physicians. He was confused about the date. When asked for the last five presidents, he could not name Kennedy, referring to him as "the one who was killed". He named four of the five largest cities, then added Annapolis. On serial 7, he made two gross mistakes and was unable to subtract further once he had reached 23. He kept insisting that he felt so much better, but after a prolonged interview, he appeared tired and dispirited.

Impression: History and mental status gave definite evidence of a marked cerebral impairment. The depressive reaction was interpreted as a secondary sign.

Follow-up: In view of the lack of clear physical evidence of brain disease, further investigation was postponed. The patient was discharged into the care of a relative who was a physician and was given an early return appointment. He never came back. We learned that he suddenly had to be hospitalized elsewhere. Upon craniotomy, a brain tumor was found.

Comment: A brain disease had caused apathy and depression in a previously active and zestful man. In this case, no circumstances of the life situation could have explained the depressive reaction which was a secondary phenomenon of brain disease.

Case 4

H.P. was a 51-year-old woman, divorced, and a sales manager.

History: The patient reported that four months prior to the psychiatric evaluation, she "hosed off the

car, threw her briefcase on the back seat, turned around to look for her purse, and went in a stroke." The "stroke" consisted of sudden left-sided jerking of the limbs and numbness. She became "hysterical", called her daughters and the police. Similar "strokes" had reoccurred since, several times every day, in varying intensity. She freely related the miseries of her past and present life. A mother who had been "mental" all her life had become more vicious since she had become senile and was "nagging her to death". Three marriages, with men who were either sadistic, sexually abnormal, insane, or who displayed combinations of these traits, had ended in divorce. One daughter from her first marriage suffered from convulsions, was nearly deaf and blind, and had four children. The second daughter, who had "a chip on her shoulder" and various physical troubles, was involved in her second unhappy marriage and had five children to care for. All along, the patient had helped her family out as much as she could, while she held a good job for the last 21 years. Just a few days prior to the onset of the patient's illness, her younger daughter's husband had gotten drunk and had become abusive toward his wife and the patient. His wife now planned to leave him. The patient had not slept and worried all night about how she could care for the five children. On the following morning, the initial episode of "stroke" took place. She felt that God was telling her through this illness that she should not burden herself with the daughter's problem and that the illness might also teach her humility, since she had always been so independent.

Physical Evaluation: The patient was seen by a neurologist and a neurosurgeon. Physical findings were essentially negative, with the exception of a mild nonspecific abnormality of the EEG. Since she cried very often and was oddly detailed and persistent about the circumstances of her life situation, she appeared to chiefly present a psychiatric problem. The possibility of a neurological disorder was remotely considered. No further neuroradiological studies were planned at the time.

Psychiatric Evaluation: A single two-hour psychiatric interview took place, on an outpatient basis. The patient was communicative and very circumstantial in relating her history. She stated that she had become progressively less alert over the past eight years and was tiring more easily. She had experienced difficulties with her memory of recent events for two years, and more so for the past six months. Her daughters had told her for some time that she was repeating herself frequently. She had always been emotional, but for the past few months would cry very easily. This trait was manifested during the interview. She made only one mistake on serial 7, but seemed tired. She recalled only four large cities in the United States when she was asked for five. She forgot Eisenhower when asked for the last five presidents. No other shortcomings of her intellectual functions were noted.

Impression: It was tempting to interpret the patient's illness as a neurosis with psychophysiologic manifestations. However, circumstantiality, affective lability, and memory deficit were clearly primary signs of cerebral impairment. In addition, this woman, until recently, had been able to function in spite of a continuous series of crises. She was referred back to the neurologist and the neurosurgeon with a note describing the psychological evidence for relatively diffuse brain damage.

Follow-up: Her peculiar emotional behavior was so impressive that further action was deferred. The patient called the examiner a few weeks after the examination to relate what she had figured out. She said that her mother had placed a curse on her some months ago for not being an obedient daughter, and predicted the punishment of sickness and death. Under the influence of this curse, so she believed, she was now subconsciously bringing this illness upon herself, which actually was no "illness". Patients with conversion reactions are not known for such insights. This enhanced the conviction that brain disease was present. Finally, she was readmitted to the hospital. A pneumoencephalogram demonstrated the presence of a mass, and upon craniotomy a tumor posterior to the right motor strip was removed. It was at first felt that the tumor had been totally excised, but the histopathology proved that this was a widely infiltrating glioblastoma.

Comment: The upsetting events immediately preceding the patient's illness can be thought of as a "red herring" finding, similar to the head injury reported in Case 3. However, it also represented a stress factor precipitating overt manifestation of illness due to the brain tumor.

Case 5

R.N. was a 37-year-old married physician.

History: For about two months prior to his admission, this patient suffered from dizziness, nausea, headaches, and anxiety with marked agitation. All this had started following an episode of "seafood poisoning". He came to the hospital from abroad for neurosurgical evaluation.

Physical Evaluation: No significant findings were obtained.

Psychiatric Evaluation: The patient was in a constant state of panic. He would exclaim, "Doctor, doctor!" or, "Where is my wife?" His wife had to be at his bedside at all times to hold his hand or to feed him. He was unable to carry a conversation. Frequently, particularly when someone approached him, he would sit up, nauseated and retching. In view of the patient's limited knowledge of English, the

constant agitation and the obvious emotional disturbance, a formal mental status examination was not done. Grossly, his level of awareness appeared to bc intact. His wife reported that two days prior to the onset of the illness the patient's close friend and brother-in-law had died. The patient had recommended that his brother-in-law go to Houston for a heart opcration and, once there, he had died on the operating table. It was also learned that the patient had becn pampered, first by a mother who had been mentally ill, then by his wife. He was not aggressive in pursuit of his carecr and "had to be pushcd". Several months before, he had accepted a leading position in a hospital, but he did not feel secure with the increased responsibility.

Impression: This chronically dependent man apparently had been pushed into a position which was more demanding than he desired. The death of the brother-in-law, for which he felt responsible, had precipitated an acute anxiety reaction with psychophysiologic reactions and possible underlying dcpression.

Follow-up: Due to an increase in the patient's agitation, he was transferred to a psychiatric ward. He left there after only two days and returned home. Meanwhile, an increased level of protein in the CSF was reported (60 mgm) and his physicians were advised that a pneumoencephalogram should be done to completc the studies. A few weeks later, upon craniotomy, an inoperable tumor was found.

Comment: It remains an open question whether a careful mental status examination would have permitted recognition of the basic disease.

Conclusion

Although only a small number of cases have been presented, certain conclusions can be drawn concerning the recognition of brain disease in patients with emotional disturbance.

The presence of a few or several of the primary signs of cerebral impairment is decisive for the diagnosis. It is not necessary to rely on a single primary sign. Deficits of recent memory and of the serial 7 performance appear to be particularly significant. The latter test is easy for a normal person of average intelligence, yet it represents a relatively sustained and complex task: the ability to subtract, retention of the last number reached, and memory of the task itself are simultaneously tested. Therefore, the test is easily failed in the presence of a degree of clouding of consciousness. Similarly, the simple but precise question of naming five of the largest cities in the United States or the last five presidents may become surprisingly difficult. Affective lability, as found in Cases 2 and 4, is not typical of an emotional disturbance, but is pathognomonic for cerebral impairment.

All cases, including the misdiagnosed Case 5, demonstratc the importancc of a protracted examination of the mental status with careful observation of the primary signs. Even though a complete physical evaluation may be negative, the presence of primary signs of cerebral impairment remains diagnostically significant.

The secondary signs are apt to mislead the diagnostician. Clearly, cerebral impairment has to be suspected if someone with intact premorbid personality unexpectedly begins to show signs of emotional disturbance. On the other hand, one needs to be particularly cautious not to miss recognition of a brain disease because of the plausibility of a neurotic or psychotic devclopment (Cases 4 and 5). Such an interpretation may seem to explain the symptom pattern of an illness and the time of its manifestation (secondary signs), but will not explain its origins.

The patients in Cases 2 and 3 reportedly had been emotionally very stable, yet they also displayed marked secondary signs with their brain disease. A more intimate knowledge of their premorbid personalities might have allowed a better understanding of these reactions. For a full understanding, one would need to have a much more precise knowledge of the psychological effects of the various cerebral lesions as well.

Finally, it should be remembered that the distinction of primary and secondary signs of cerebral impairment chiefly serves a diagnostic purpose. In reality, the two sets of mental changes are constantly interacting. The leading primary sign, clouding of consciousness with impairment of attention, thinking, and memory, implies an impairment of ego functions.[4] The most highly differentiated mental functions appear to be the most vulnerable to cerebral disease. The associated emotional disturbances, the secondary signs, are largely a result of the primary ego changes. Such a view would explain why only the primary signs are specific for cerebral impairment.

REFERENCES

1. Conrad, K.: Die symptomatischen Psychosen. *In Psychiatrie der Gegenwart,* vol. II, ed. by Gruhle, H. W., et al, Berlin-Göttingen-Heidelberg, 1960.
2. Cobb, S.: Neurology. *American Handbook of Psychiatry,* vol. II, New York: 1959.
3. Romano, J., and Engel, G. L.: Delirium: I. Electroencephalographic Data. *Arch Neurol & Psychiat* **51**:356, 1944.
4. Romano, J., and Coon, G. P.: Physiologic and Psychologic Studies in Spontaneous Hypoglycemia, *Psychosom Med* **4**:283, 1942.
5. Bleuler, E.: *Lehrbuch der Psychiatrie,* Berlin-Göttingen-Heidelberg, 1949.
6. Mulder, D. W.: Psychoses with Brain Tumors and other Chronic Neurologic Disorders. *American Handbook of Psychiatry,* vol. II, New York, 1959.
7. Scheid, W.: "Die psychischen Störungen bei Infektions-und Tropen-Krankheiten." *Psychiatrie der Gegenwart,* vol. II, ed. by Gruhle, H. W., et al, Berlin-Göttingen-Heidelberg, 1960.
8. Faust, C.: Die psychischen Störungen nach Hirntraumen. *In Psychiatrie der Gegenwart,* vol. II, ed. by Gruhle, H. W., et al, Berlin-Göttingen-Heidelberg, 1960.

The task of discriminating between organic and functional illness involves recognizing those subtleties that may misguide even the most experienced clinician in making a correct diagnosis. This paper is concerned with separating those patients with true psychiatric problems from those who have been mistakenly classified as psychiatric, when they unfortunately have organic reasons for their problems—subdural hematomas, brain tumors, multiple sclerosis, etc.

Diagnosing Organic Psychosis

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An Appraisal of Reality

The reality of our environment encompasses the perception of daily living, which is a summation of multiple pieces of information received through the central nervous system. Reality also reflects our selective perception of those events which take place within the total environment. If this reality is congruent with that which actually exists in our environment, then one considers perception to be normal. When there is a deviation from this standard, others become concerned and regard this as a measure of abnormal thinking, feeling, or behavior.

Viewing the problem simplistically, one might consider the brain as a type of mechanical monitor. With such an operational model there may be several areas in which potential difficulties could arise.

First, there can be a distortion of reality if the perceptive apparatus is malfunctioning and there is no input data. When input data is absent, as in the case of sudden blindness or traumatic amputation, it illustrates the end-organ deficit and the absence of sensory information necessary for accurate perception.

Even though the input information is accurate, such data must first be collected, identified, and organized before it can be synthesized and used, if it is to be meaningful. Afferent sensory pathways help in discerning size, shape, texture, touch, heat, pain, and space relationships, as well as many other inputs. Visual reinforcement, hearing, tasting, and smelling all contribute to the enormous data impinging on the central nervous system. Once received, these separate data require cerebral functions to be effective, including memory, abstraction, conceptualization, symbolization, etc. In computer language, input data must be codified for reference purposes. This inability to codify and synthesize input data is reflected by clinical measurements and labeled descriptively as confusion and disorientation.

Finally, the response to assimilated information accurately perceived and integrated may reflect impairment and be interpreted as reflecting abnormal thinking, feeling, or behavior. Pure motor aphasia illustrates this type of deficit. The individual may recognize the object presented to him and know its use and function but is unable to call it by name. In other words, the individual receives and integrates the incoming information but is incapable of appropriately responding to the signal received.

Homeostatic Mechanisms

The nervous system is known for its limited regenerative powers following injury. The homeostasis of the central nervous system is maintained through compensatory mechanisms in the face of cerebral impairment. Although these compensatory mechanisms may be under partial conscious or unconscious control, by and large they reflect either a psychological reaction to the loss of functioning tissue, or the recruitment of more primitive but less impaired levels of central nervous system function.

An example of conscious recognition of diminishing cerebral faculties is the appointment book carried in a man's breast pocket. This functions as a stimulus for memory recall and compensates for the loss of cortical neurons with the aging process. In a similar fashion, the familiar night light by the bed stand helps the elderly patient to increase his perceptual cognitive abilities by structuring his environment and permitting him a greater feeling of comfort and security. The night light compensates for decreasing visual, auditory, and cortical monitoring

efficiency by orienting the patient to the reality of his immediate surroundings.

Organicity

In 1884, Hughling Jackson [1] postulated that the central nervous system was a hierarchy of differing levels of function and that the greater the complexity, the more recent its evolutionary development and degree of specialization.

Therefore, in the presence of insult to the central nervous system, these higher specialized functions seem to be the first to suffer. As might be expected, there is a loss of abstractive thinking and the uncovering of more primitive concrete responses which reflect a lower level of functioning.

As an illustration, unlocking the door with a key represents an habitual and concrete act that requires little cognition. If the key does not fit the lock, one would recognize that either it was the wrong key or that perhaps it was the wrong door. This reflects an abstractive ability to assess a series of conceptual alternatives when faced with momentary failure, ie, not being able to open the door. On the other hand, to continue to force the key with an automatic and repetitive movement would be a measure of the inability to change the engram imprinted cortically which says, in effect, that the key should turn the lock. It also tends to negate the possibility of considering alternatives.

Signs of organic brain damage are relatively easy to discover if one is alert to them. Some signs are confabulation, circumstantiality, and perseveration.

In confabulation, the patient makes up stories. It is as if the individual assumes that he should have the necessary information at hand and will agree, therefore, in an effort to please the examiner. Thus, by talking in a knowledgeable fashion, the patient helps in denying the extent to which his memory is impaired and may, in fact, begin to actually believe his story.

Circumstantiality is the circular rambling patients exhibit when they attempt to grasp a word or thought. It reflects their inability to screen out important from unimportant information, as seen with frontal lobe damage.

Irritability is frequently encountered with cerebral impairment. Although it may stem from multiple sources including those which are psychological, sometimes the irritability is directly related to the injury. To some extent, irritability represents tension release within the central nervous system which may occur when inhibitory influences of the cortex are impaired. The hyperacusis with temporal lobe damage or the thalamic syndrome with extreme hypersensitivity to touch are examples of irritability.

Irritability can be compared to pathological reflexes or to other abnormal movements found in the central nervous system, which are a result of the loss of higher function controls. Chorea, hemiballismus, and the cogwheel tremor in paralysis agitans are examples of this type of release phenomenon.

Memory loss, particularly for recent events, is very common. One should be alert to people who forget some things and not others, as such conditions may be mistaken for memory loss when aphasia may be the basis for their difficulty. Impaired judgment reflected by loss of integrative capacities also demonstrates impulsive overreaction in the face of diminished capacities.

Psychological Defense Mechanisms

The psychological mechanisms used in coping with cerebral impairment are seen in conscious and unconscious denial. There is, however, some evidence to suggest that denial may not be entirely psychological but may, in fact, reflect the lack of integrity of the central nervous system. To this latter point, the examiner's interpretation of denial in the patient regarding his paralyzed side is sometimes seen with cerebrovascular accidents in the frontoparietal area.[2]

In addition, psychological defense mechanisms are in evidence in those individuals who refuse to accept the reality of their disability and thereby deny it, or those, for example, who project their feelings by unjustly blaming the physician for not preventing the illness. Finally, there are those who overcompensate by attempting physical and mental tasks for which they are no longer suited.

The regressive behavior and the tendency of patients to preoccupy themselves with bodily functions and somatic complaints, for example, reflect other psychological means for coping with these stress situations.

If one studies an organically impaired subject given a task and allows the individual to persist unsuccessfully, one may witness what has been described as a catastrophic reaction. This is manifested by an emotional outburst or a rage reaction, frequently accompanied by confusion and, at times, with physical assaultiveness. The behavior reflects the patient's response to the impairment of higher central nervous system functions characterized by hyperirritability, increasing tension release, and finally, psychological collapse.

If these people are studied over a period of time, one discovers that despite the fact that their impairment remains essentially unchanged, there seems to be a tendency towards a decreased incidence of catastrophic reactions. This is not necessarily a measure of behavioral improvement but rather a result of developing awareness regarding stressful situations and the individual's tendency to isolate himself and to avoid those states leading to further failure and frustration.

Establishing the Diagnosis

The anatomical correlates of early neurological disease mimicking various psychiatric disorders help to clarify the protean nature of the types of symptoms that may be presented by a patient. The associational pathways connecting topographically distant areas of the brain are possible through superficial and deep longitudinal fasciculi and U fiber connections between proximal gyri. Therefore, in lesions in the frontal lobe area it is possible to develop temporal lobe symptoms via the uncinate fasciculus or occipital lobe symptoms through other associational pathways.

The brain is essentially contained in a nonexpansible box. Our concerns are not for space-occupying lesions in the posterior fossa, which usually are diagnosed early in their development because of their proximity to specialized tracts and nuclei. Our principal concern is for the space-occupying lesion in the frontal lobe area, which is capable of considerable growth and expansion before the development of such obvious neurological signs as long-tract symptoms or papilledema.

Chapman and Wolff [3] indicated that in patients with as little loss as 30 to 60 gm of cerebral tissue, it is possible to detect impairment of imagery and curiosity, reluctance to undertake new adventures, loss of spontaneity and rapid learning, and the tendency to become disorganized under stress.

The difficulty in separating such a description of early cerebral impairment from the description of an individual developing a depressive reaction is indeed an extremely difficult task. There are, however, several specific suggestions which may be offered.

A carefully detailed history of the individual's employment, his social contacts, and his relationship with other family members, all become extremely valuable. Taking a detailed history from several people such as the spouse, an employer, or a fellow worker may effectively document chronological changes and help establish an early diagnosis.

Depressive Reactions

Depressive reactions (except for a few) have clearly associated life factors which antedate the depressive episode. There are usually other examples of psychological instability found in the patient's life as one listens closely to the background information given by the psychiatric patient with depressive symptoms. Many patients have recurrent adjustment problems in life—they may develop overly-dependent relationships with others, or they may be hypersensitive and react with feelings of rejection and are inclined, in short, to make mountains out of molehills.

The diagnosis of a depressive reaction should be made with extreme caution in a relatively well-adjusted individual with a stable family and employment situation and in whom antecedent events are lacking to explain the onset of the depression. The diagnosis should be held in suspect and an organic basis for the depression should be carefully looked for. It should be remembered that psychological stress can also precipitate an underlying organic illness and each individual case requires careful evaluation.

Toxic States

There are, in addition, a variety of toxic states which may resemble psychoneuroses or psychotic illnesses. Most physicians are familiar with the bizarre reactions patients have to scopolamine, narcotics, barbiturates, and alcohol. In these instances, the physician can easily identify the patient's medications and quickly withdraw the offending agent. There are, however, those self-prescribed medications which may create organic states resembling functional illness and may be a diagnostic problem.

One must make specific inquiries concerning medications used, since this type of information is frequently not volunteered or even remembered by the patient. It is worthwhile asking family members to bring in all medicines used in the home, including patent medicines. When medications are taken daily, patients are likely to overlook them as specific medicants as they constitute actions that are taken for granted.

A medical problem encountered in as high as 4% of some psychiatric clinics in the United States is that of acute and chronic bromide intoxication.[4] Since bromides are available in a variety of proprietary medications, they are, in effect, an inexpensive form of tranquilizer for those with limited funds and who have realistic life problems. Although relatively rare in younger age groups, bromide intoxication occurs with increasing frequency after the age of 30 and, as might be expected, is particularly prominent between the ages of 50 to 70.

Like many central nervous system depressants, the ingestion of bromides creates symptoms related to its pharmacological effect. When taken for ordinary headaches, bromides give temporary relief. Their use is followed by obtunding of CNS functions with apathy, irritability, generalized dulling, and, unfortunately, the return of the headache. Often this leads to a desire to continue taking additional bromides in an effort to alleviate the aftereffects of withdrawal and its rebound phenomena.

In an earlier study [5] in a city of 200,000 people, 65,000 lb of one major bromide-containing proprietary medication was sold in one year. Sixty-five thousand pounds is equivalent to 7,250,000 doses of bromides containing 150 mg each. When serum levels approximate 100 to 150 mg per 100 ml of blood serum, bromides are considered toxic and

symptomatic and may lead to confusional states, hallucinations, memory defects with confabulation, or the creation of stories, delusions, and neurological signs of organic brain disease. It is frequently misdiagnosed as schizophrenia and these patients unfortunately are admitted to mental institutions. Recognizing the preference many physicians have in prescribing bromides, it is suggested that prescriptions be written as nonrefillable in order to maintain some control over their indiscriminate use.

Huntington's Chorea

Degenerative central nervous system diseases such as Huntington's chorea can be overlooked in favor of a functional illness. Huntington's chorea was first described in 1872 by tracing a hereditary disorder within Dr. Huntington's own family, through an account of the disease in his grandfather, his father, and himself.[6] The disease is thought to be transmitted via a single dominant gene with incomplete penetrance. The neuropathologic lesion is related to its degenerative changes in the nerve cells of the putamen particularly in its posterior aspect and also in the head of the caudate nucleus. Over time, the cerebral hemispheres atrophy and the white matter is affected more than the gray.

Huntington's chorea is best described as a genetically-determined degenerative disease associated with abnormal choreiform movements, usually behavioral changes, and progressive dementia. The establishment of an early diagnosis is extremely important in an effort to limit progeny within the patient's family. In a series of 35 cases of Huntington's chorea that were reviewed, the earliest symptoms noted were behavioral changes. A common complaint is restlessness with associated unexpected behavior. There can be, for example, promiscuous sexual acts or behavior reflecting poor judgment and viewed as antisocial. As the disease progresses, the patient may be misdiagnosed as schizophrenic. With the appearance of choreiform movements, the diagnosis becomes self-evident and there is, over time, the development of grimacing facial movements, dysarthria, general incoordination, and the dancing ataxic gait so characteristic of this disease.

The degenerative disease is associated with depressive episodes and a high suicide rate. Dementia ordinarily is a later development. The individual patient must face a deteriorative process with progressive, uncontrollable, abnormal movements in the face of relatively intact intellectual functions. What may seem a product of the disease may, in reality, reflect the patient's psychological reaction. This distinction needs to be made in the patient's management.

Porphyria

Porphyria is sometimes misdiagnosed as a psychiatric problem if a patient presents himself with anxiety and vague symptomatology. The mental symptoms may be mistaken for an anxiety neurosis or a psychotic reaction and the inconstant neurologic signs and symptoms may not help in clarifying the underlying disease.

In this Mendelian dominant disorder, the presenting complaint may be abdominal pain without localizing signs and can be confused for gallbladder, intestinal, or pancreatic disease. It should be remembered that an acute attack may be precipitated by barbiturate ingestion. The diagnosis of porphyria, using Ehrlich's reagent, is a simple procedure and its early detection may be helpful in aborting a severe attack of porphyria.

An Approach

In the not too distant past, surveys in public mental institutions revealed that as many as 5% of those patients autopsied had brain tumors. Unfortunately, there are no easy operational rules that one can follow in separating curable neurological lesions from that group of psychiatric patients with the diagnostic label of neurosis or psychosis. Perhaps the physician's single most useful tool is listening very carefully, with a high index of suspicion, to the patient's history. To the astute clinician, early signs of organicity can be detected as easily as the assessment of early decompensation in the cardiorespiratory system.

The distinction between functionally deranged and organically deranged patients can be ascertained by listening carefully and assessing the total functioning status of the individual. Frequent reexaminations will help to detect the minor changes or deteriorative processes within patients. It is essential to develop a high degree of curiosity and perhaps some professional suspicion for underlying disease.

All of us become experts retrospectively. When we consider those occasional central nervous system diagnoses that are missed by most physicians, the subtle differences in symptoms of a particular case contrasted to functional neurotics and psychotics become more apparent.

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REFERENCES

1. Jackson, J. H.: Croonian Lectures on the Evolution and Dissolution of the Nervous System. *Lancet* **1**:535, 649, 734, 1884.
2. Critchley, M.: *The Parietal Lobes,* London: Edward Arnold & Co., 1953.
3. Chapman, L. F., and Wolff, H. G.: Studies in Human Cerebral Hemisphere Function: Adaptive Capacity After Loss of Hemisphere Tissue. *Trans Amer Neurol Ass* **81**:175-178, 1956.
4. Walshe, F. M. R.: *Diseases of the Nervous System,* ed 7, Baltimore: Williams and Wilkins, 1952.
5. Grosser, B.: Personal communication, 1962.
6. Huntington, G.: On Chorea. *Med and Surg Reporter* **26**:317, 1872.

Physicians frequently encounter patients showing disturbed behavior for whom a differential diagnosis may be both difficult and crucial. This can be especially true as it relates to functional versus organic or toxic psychoses.

Organic Versus Functional Psychosis: Differential Diagnosis

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Neuroses

While the term neurotic is commonly used to describe individuals who show certain manifestations of maladjustment, actually defining the word can be exceedingly difficult. The psychoneurotic disorders are characterized by anxiety, which is directly felt or expressed, or which may be defended against by various psychological defense mechanisms.

Patients with psychoneurotic disorders do not exhibit gross distortion or falsification of external reality. They do not have delusions or hallucinations and they usually do not battle with gross disorganizations of personality. Patients in this group suffer from anxiety reactions, phobia, conversion, obsessive-compulsions, and neurotic depressive reactions.

Character Disorders

Individuals with character disorders do not use mental or emotional symptoms to secure adjustment but make use of certain patterns of behavior or actions. They usually do not have much overt anxiety but have their own, usually lifelong, behavioral ways of dealing with people and problems.

Probably the most common group in the average, middle class population is that of the obsessive-compulsive personality. These individuals are rigid, meticulous, fastidious, and are riddled by doubt. They are the chronic worriers. They lack a normal capacity for relaxation. They are stubborn and have a great tendency to "split hairs". They often are harassed by their sense of responsibility and have difficulty in making decisions.

Another common group is composed of individuals who are exceedingly emotionally labile. They are usually women who tend to exaggerate everything to get attention. They are easily frustrated and do not have the ability to stick with a task.

Other groups include the chronically inadequate, the schizoid, and the paranoid personalities.

Psychophysiologic Reactions

The term psychophysiologic reaction is used synonymously with the word psychosomatic to describe such well-known conditions as peptic ulcer, ulcerative colitis, and functional hypertension. Under the somatic disorder, almost any sort of psychiatric picture may be found. The range is from a relatively well-integrated person, to a severe neurotic, to a seriously disturbed person who functions to a certain extent in a psychotic way, with little ability for reality testing.

Psychoses

Psychoses are classified as either functional or organic. The schizophrenic (functional) disorders may be broken down as acute and chronic, and the process may be accurately described by these terms. The chronic process is one in which there is a gradual, insidious but progressive deterioration of the individual over the years. The acute schizophrenic process can appear in a matter of hours to days. This is not to say that the signs of emotional disturbance were not present before the acute breakdown.

Schizophrenias are manifest in several ways. They all show, to a certain degree, a disturbance in the reality relationships and concept formations. They also show emotional, behavioral, and intellectual disturbances. Their behavior is marked by a strong tendency to retreat from reality, by an unpredictability in their stream of thought, and by various regressive types of behavior. There may be some depressive aspects to this behavior, but it is important not to be confused by the word "depression" which the patient and relatives may use to describe the situation, and thus overlook the underlying schizophrenic process.

If antidepressive medications are given to an individual who is fundamentally schizophrenic, it will probably only make the condition worse.

The manic-depressive group comprises psychotic reactions which are marked by severe mood swings with a tendency to remission and recurrence. These individuals may have such manifestations as illusions, delusions, and hallucinations, but these are usually minimal, and the remarkable thing is the disturbance in the mood.

Classically, the manic shows elation or irritability with over-talkativeness, flight of ideas, and increased motor activity. Usually, the so-called elation thinly masks great hostility or depression.

At the opposite end of the pendulum is the depressed-depressed where there is marked retardation of thinking and actions. There may be delusions, usually concerning how evil the person thinks he is or his being sure that he has some dread disease. Guilt and worthlessness are all-pervasive in the depressed-depressed.

But more commonly, one sees the group that is referred to as the agitated-depressed. Such an individual, while feeling hopeless and helpless, does not think that he is worthless and makes constant demands for attention and help. There is a degree of agitation, significant bodily preoccupation, plus the insomnia and the anorexia that are usually present in all three of the manic-depressive groups. Infrequently, one finds these individuals sleeping or eating excessively as a last-ditch defense against an overt depression.

The organic states are those that are classified as either acute or chronic brain syndromes. In the acute, not only is the onset abrupt, but the situation is theoretically only temporary. There is diffuse involvement of the brain tissue function, but it is reversible if treated in time.

In the chronic brain syndrome, one finds relatively permanent, irreversible and diffuse impairment of cerebral function. With specific treatment this process may partially subside, but there is some residual destruction of the brain tissue. Of course, the acute syndromes may become chronic depending upon the rapidity and effectiveness of treatment.

Acute brain syndrome is synonymous with "delirium". There is a variable depression of function of the high cerebral centers short of coma. External and internal stimuli still reach the mind but there is a failure of recognition, integration, and control resulting in disordered perception, thought, and behavior.

The most common states, which present problems in differential diagnosis, are the acute schizophrenic states and the acute toxic conditions. A few definitions may be helpful in making differential diagnoses.

1. A delusion is a disorder of thinking. It is a false belief which may have started with a slight basis in reality, but as it becomes elaborated in the individual's mind, the delusion has a stronger meaning to him than has reality. Any attempt to demonstrate its falseness does not convince the individual.

2. The forerunner of a delusion is an idea of reference. An idea of reference is something that actually happens in reality such as a remark or an action from other people. In no way does it refer to the patient but is interpreted by him as being significantly related to him in some way that is malicious, accusing, or depreciating. An example of an idea of reference is an individual who gets on the bus and feels that other people are talking about him in some accusatory fashion. Actually, the people on the bus are talking, but not about him, and especially not in the malicious way in which the individual perceives it.

3. An hallucination is a false sensory perception. False perceptions may occur in any of the sensory modalities. The most common are experienced in the visual and auditory spheres but they can also be found in the touch, smell, and taste areas.

4. The forerunner of an hallucination is an illusion. An illusion is the result of a real sensory perception which is misinterpreted. These false perceptions are usually quickly corrected. For example, a patient who is delirious may say, "I know that that is a doorknob, but it looks like a cat's face."

A number of areas have to be considered when making the differential diagnosis between an acute schizophrenic process and a delirious process (Table 1).

Table 1: Differentiating Between Acute Schizophrenic and Delirious Processes

Mental Status	Functional (Acute Schizophrenic)	Organic (Acute Delirium)
Appearance and Behavior	Rarely useful differentially	
Emotional Reaction	" " "	
Stream of Speech	" " "	
Thinking Disorder	Ideas of Reference and Delusions Common	Not as Prominent or Fixed
Perception	Hallucinations (Auditory) Usually Prominent, Patient Secretive About Them	Illusions and Hallucinations (Visual and Auditory) Prominent
Orientation	Frequently Intact	Disturbed
Memory	Frequently Intact	Disturbed
Abstract Thinking		
Time of Occurrence	Anytime	More Intense at Night

Both types of patients may be quite disheveled and preoccupied. There is little to differentiate between the two except that the toxic individual appears to be quite pale, weak, and shows gross evidence of organic illness. The emotional reactions of both may range from detachment to panic, so this is not very helpful. The stream of speech of both may be quite disorganized and possibly incomprehensible. However, the delirious patient is more likely to speak spontaneously and look for help, whereas the acutely schizophrenic patient is less likely to be aware of others and more preoccupied with what is going on inside himself.

The schizophrenic is most likely to have ideas of reference. Delusions are also prominent. These delusions may be relatively simple such as, "They are out to get me". The "they" usually is rather vague. Or else the delusions may be very complicated, such as a delusion about a very highly organized spy system.

Delusions frequently reflect the culture of the time. For example, it used to be that these individuals thought that they were being talked about on the radio. Then it was the television that had some special influence on them. Now, many of them believe that things or people in outer space are maneuvering them. In an acute delirious process, ideas of reference and delusions are minimal to absent.

Hallucinations are less prominent in the schizophrenic. If he has any false sensory perceptions, he usually tends to be very secretive about them and is reluctant to tell anyone. If he has hallucinations, they most frequently occur in the auditory sphere. The voices will be accusing him. Seldom will he be able to identify the voice. If he has visual hallucinations, they tend to be ill-defined and of a mystical nature such as the shadowy figure of God. Hallucinations in other spheres are relatively uncommon and can only be ascertained with a lot of questioning.

In contrast to the schizophrenic, the delirious patient has illusions which progress to very prominent hallucinations. Visual hallucinations are most common in the toxic states; auditory experiences run a close second. Delirious patients tend to be exceedingly verbal about these hallucinations and after the acute situation is over, they will recall them in great and vivid detail.

The false visual perceptions may include imaginary flashes of light or colored forms, or they may be of quite complex scenes. One man saw a beautiful sailboat made of magnesium. Other patients have seen butterflies, kittens, funerals, and even little green pegleg men running up and down a wall.

The visual phenomena also include the familiar little bugs which the patient attempts to pick at, either on the bed, in the air, or on his skin. Occasionally the person imagines smells such as leaves or burning rubber.

The hallucinations in the auditory spheres of delirious patients tend to be of bells ringing, music playing, or streetcars clanging. Voices are usually identified as saying something that has been said in reality, such as the voice of a wife reprimanding a patient for drinking.

In addition to these, there are also toxic hallucinations. Toxic hallucinations are impersonal and have no dynamic meaning to the individual. For instance, the little green pegleg men running up and down the wall could not possibly mean anything.

A certain number of delirious patients will have the type of experiences that are common to a schizophrenic. They will actually feel that they are being

tortured by their hallucinations, which will put the patient into a panic state.

A few delirious patients will appear to have paranoid-like delusions. For example, a patient admitted with pneumonia may perceive that the orderly coming to take his rectal temperature is attempting homosexual assault. This patient, when taken to X-ray, feels that the machines are doing terrible things to him and he may go running out of the X-ray department.

One patient with typhoid had ideas of reference. She was sure that a policeman who just happened to come to the ward was going to take her to jail because of a criminal abortion that she had had some years before. This patient heard the nurses making some mention of a hot tub of water and immediately she thought that they were going to put her into it and scald her. In order to prevent being scalded, she took a pocket mirror and attempted to kill herself by slashing her wrists.

Two other very important areas differentiate the delirious patient from the acutely schizophrenic. These are orientation and memory. Both are disturbed in the delirious patient and intact in the schizophrenic. This recognition is exceedingly important.

Frequently, physicians who are discussing a schizophrenic patient express surprise at the fact that the patient is fully oriented and his memory is intact. But schizophrenics do not have problems in orientation and memory. The only times that they are disoriented are when they use time for symbolic reasoning, or when they have been so preoccupied with their inner experiences that they have lost track of time. Given a simple task to remember, they certainly will remember it.

However, in the delirious patient, because of his perceptual difficulties, orientation diminishes, first as to time, then as to place, and then as to person. In these areas of disorientation, they are most likely to make the unfamiliar become the familiar. Usually, the patient thinks that the nurse is his sister, and that the physician is his brother. The hospital becomes his home, or his school, or whatever is most familiar to him.

As his consciousness becomes more impaired, memory for immediate, recent, and past events, in that order, becomes clouded. It is quite common for the delirious patient to become more anxious and disturbed at night since there are fewer sensory guides to help him in his orientation. The shadowy darkness and the absence of familiar persons contribute to this. This accounts for the fact that there is a frequent report by night nurses that the patient suddenly became delirious. Most often the patient has already been delirious but did not manifest bizarre behavior during the day.

The causes for this delirious state are a mixture of low-grade fever, some dehydration, plus whatever other noxious agents may be present. The term "infective exhaustive psychosis" is an apt one to describe a situation where a number of factors contribute to the delirium.

In addition to the medical measures that are taken, it is helpful to explain to the patient that he is delirious. Most individuals who are able to comprehend anything have some knowledge of what a delirium is and they are at least transiently reassured to know what is happening to them. They may have felt that they were going crazy.

If the delirious patient can be kept in a room by himself where there is not much confusing outside stimuli, he will have less perceptual distortion. At night it is well to keep the lights on so there will not be so many shadows to be misinterpreted. It is helpful to have a family member stay with the patient. In addition, unless it is medically contraindicated, the phenothiazines, especially thioridazine (*Mellaril*) and chlorpromazine (*Thorazine*), are quite useful in cutting down the anxiety.

There are other cases where medical conditions present themselves as psychologic disorders. Acute intermittent porphyria, pernicious anemia, and endocrine disorders are three of these.

Acute intermittent porphyria is a grossly hysterical, delirious, or manic-like state which can be so prominent as to obscure any abdominal or neurological symptoms, which may or may not be present.

In pernicious anemia, the cerebral symptoms are not necessarily attributable to anemia and include dullness, apathy, irritability, and loss of concentration. All of these could add up to mild depression.

In endocrine disorders, the lethargy, psychomotor retardation, and fatigue of early hypothyroidism appear to be depression. The excitability, irritability and general overactivity of hyperthyroidism appear to be mania. The mental symptoms of hyperfunction of the parathyroid gland have received little attention. Headache and irritability and a loss of capacity to concentrate may be a result of the hypercalcemic state.

Since many hysterical phenomena accompanying hyperventilation can resemble the tetany of hypoparathyroidism, a problem in diagnosis may exist.

Adrenocortical dysfunction, hypo or hyper, as well as the steroids given as medication, may all result in profound psychological difficulties of a variable nature ranging from depression, to a paranoia, to a toxic-like psychosis.

With the ubiquity of psychotropic drugs, physicians would do well to take care in prescribing drugs to disturbed patients in order not to obscure metabolic, toxic, or other psychologic disorders. A thorough, differential diagnosis of a disturbed patient may be difficult for the patient to undergo, yet it is of the utmost importance in determining and treating his psychosis.



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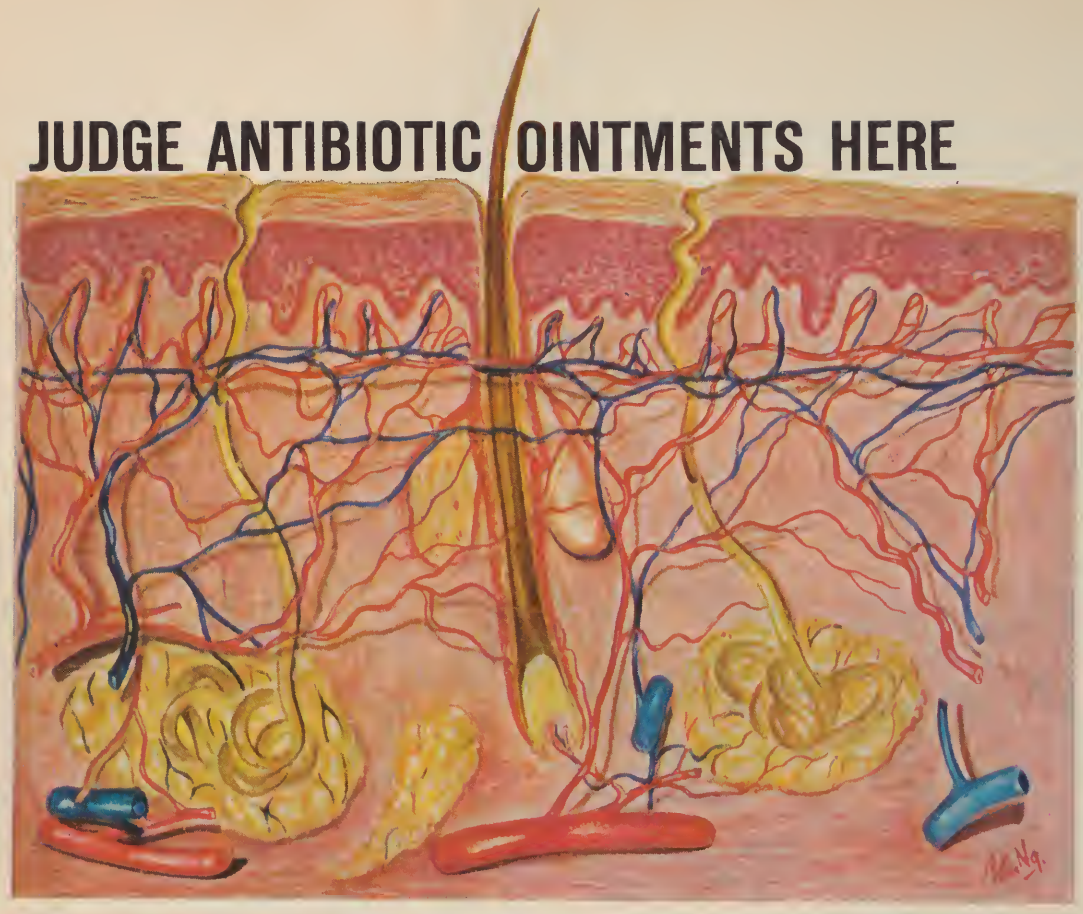
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by John Sargeant
Executive Director

The Council met on September 10, 1970, at Hershey, Pa., and took the following actions:

1. Granted Emeritus Membership to Robert B. Mitchell, MD, of Baltimore, at the request of the Baltimore City Medical Society;
2. Adopted financial statements through July 31, 1970;
3. Rescinded previous actions of the Council, taken in 1956 and 1963, that required the library to charge for the preparation of bibliographies;
4. Voted to take no action on a suggested protest to the Food and Drug Administration concerning the production of ampules of Vitamin B_{12} in 1,000 μg doses or higher. The suggested protest was requested by a Faculty member;
5. Received for information a communication from the AMA dealing with the Social Security Administration's receiving legal authority to direct fiscal intermediaries on how to determine Usual, Customary and Reasonable fee structures;
6. Heard a presentation by Mr. Chad Combs, AMA representative, on the AMA's Medicredit proposal;
7. Agreed to hold a special Council session to discuss the various proposals now before Congress on National Health Insurance, the Task Force Report on Medicaid and Related Programs made to the U.S. Secretary of Health, Education, and Welfare, the Foundations for Medical Care concept, and the current discussions taking place with representatives of the AFL/CIO;
8. Agreed to waive the 1970 dues for a member at the request of his component society;
9. Declined to adopt a motion that would have committed each Council member to make a contribution to Echo House, but urged each member to consider making such a donation. The Council also authorized mailing material concerning Echo House to all Faculty members;
10. Agreed to request full details from the Secretary of Health and Mental Hygiene on the prepaid medical programs reportedly negotiated with three medical institutions in Baltimore city. The Council also agreed to ascertain additional information concerning other areas of involvement in this connection, to be discussed at a future Council meeting;
11. Approved the change in name of the Future Nurses Club to the Health Careers Club, and endorsed Woman's Auxiliary participation in this endeavor;
12. Recognized officially the receipt of an additional $110 to be added to the Laughlin Award Fund, which now totals $3,420.95;
13. Heard that the courts had ruled that the petitions to referendum on a bond issue in Charles County were invalid. The petitions had prevented implementing legislation that authorized funding for additional beds at the Physicians Memorial Hospital in La Plata.

The Executive Committee met on September 10, 1970, and took the following actions:

1. Provided the Air Quality Control Advisory Council with the names of three physicians qualified to act as consultants to the Council;
2. Approved of the Faculty office maintaining a list of qualified persons who could assist in preparing grant applications to the federal government. The fiscal arrangements would be completed directly between those involved, with no Faculty responsibility or cost;
3. Agreed to proceed, in depth, with the Professional Liability Study and to investigate sources of funding;

(Continued next page)

4. Heard that several Professional Corporations formed under this new statute appeared to be illegal and that this had been brought to the attention of the State Department of Assessments and Taxation. The violations involved nonlicensed persons being included as incorporators or shareholders;
5. Approved development of a car rental program to be made available to Faculty members;
6. Authorized a $500 contribution, for educational purposes, to the MMPAC;
7. Agreed to ask component medical society officers to indicate whether they wish to continue receiving mailed copies of Executive Committee and Council minutes, as well as financial data;
8. Approved recommending to the Commissioner of Motor Vehicles the appointment of DeWitt E. DeLawter, MD, of Chevy Chase, to the Medical Advisory Board of the Department;
9. Approved a joint meeting with the Hospital Council Executive Committee on Thursday, December 10, 1970;
10. Determined that a representative group of the Executive Committee should meet with Kent County Medical Society officials to resolve a problem that has developed with the court system and law enforcement officers in that county;
11. Referred to the Ad Hoc Committee on Salmonellosis the question of adoption of the Responsibilities of a Medical Director (of a nursing home, ECF, etc.).





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Letter to the Editor

Dear Sir:

In the August issue of the *Maryland State Medical Journal* I observed the comment about *The Johns Hopkins Medical Journal* and its "demise." The purpose of this letter is to give you definitive information about *The Journal* which, fortunately, has not died.

Economic considerations led the former editorial board of The Journal to recommend to the Advisory Board of The Medical Faculty that, unless vigorous support by the Advisory Board could be guaranteed, consideration be given to termination of the publication of The Journal. The Advisory Board concurred with the recommendation to discontinue The Journal. When the facts were presented to the entire faculty, however, that body expressed such overwhelming interest in the continuance of The Journal that the Advisory Board reversed its decision. Thus, a new Editorial Committee, chaired by Dr. Thomas B. Turner, Dean Emeritus, was appointed, a new editorial policy adopted, and The Journal survived. There will be no break in the continuity of publication, though there will be an understandable delay in the appearance of the July issue, the first issue under the new editors.

The Johns Hopkins Medical Journal, established in 1889 as the *Johns Hopkins Hospital Bulletin,* has a long and distinguished record, and the new Editorial Committee plans to publish, as stated in the new policy, "results of original research and reviews, especially of interdisciplinary interest to those working in the biomedical sciences, and to those in the broadest sense involved in the practice of medicine. It is designed particularly to reflect the contributions of present and former faculty, staff and students of the Johns Hopkins Medical Institutions. In addition, contributions from others are welcome." The present list of subscribers numbers over 9,200.

It seems appropriate that this information be brought to your attention, as you may wish to publish a correction in a forthcoming issue of the *Maryland State Medical Journal.*

Very sincerely yours,
R. Carmichael Tilghman, MD
Editor
The Johns Hopkins Medical Journal

A Chicago editor pinned this note on the bulletin board: "'Let's set our sights high. Let's learn to spell 'judgment' with out an 'e'." Signed: Deranged.

The next morning a reporter pinned a note on the bulletin board replying: "Dear Dranged: 'I tried to spell jusgment without and 'e' and it came out judgment. Now, I am in a predicament.—Confused'."

OCTOBER 16, 1970 — 12:30 PM

ALCOHOLISM

Esteban Mezey, MD
Assistant Professor of Medicine
Johns Hopkins University School of Medicine

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Replays:	Monday, October 19, 1970	12:30 PM
	Wednesday, October 21, 1970	7:30 AM
		9:00 AM
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OCTOBER 23, 1970 — 12:30 PM

SUBDURAL EFFUSIONS

Robert M. N. Crosby, MD
Associate Professor of Neurological Surgery
Instructor in Pediatrics
University of Maryland School of Medicine

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, October 26, 1970	12:30 PM
	Wednesday, October 28, 1970	7:30 AM
		9:00 AM
		2:00 PM

OCTOBER 30, 1970 — 12:30 PM

WHO CARES FOR THE ALCOHOLIC

(A live interview with an alcoholic)

Maxwell N. Weisman, MD
Director, Division of Alcoholism Control
State Department of Health and Mental Hygiene

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Replays:	Monday, November 2, 1970	12:30 PM
	Wednesday, November 4, 1970	7:30 AM
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NOVEMBER 4, 1970 — 8:00 PM

COMPLICATIONS OF RHEUMATOID DISEASE

Lawrence E. Shulman, MD
Associate Professor of Medicine
Johns Hopkins University School of Medicine

Lee H. Riley, Jr., MD
Associate Professor of Orthopedic Surgery
Johns Hopkins University School of Medicine

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Replays:	Friday, November 6, 1970	12:30 PM
	Monday, November 9, 1970	12:30 PM
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		9:00 AM
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NOVEMBER 13, 1970 — 12:30 PM

BACTERIAL ENTERITIS

Herbert L. Dupont, MD
Instructor, Infectious Disease Division
University of Maryland School of Medicine

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Replays:	Monday, November 16, 1970	12:30 PM
	Wednesday, November 18, 1970	7:30 AM
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MEDIC
1970 SCHEDULE

NOVEMBER 20, 1970 — 12:30 PM

COMA — THE PHYSICIAN AND THE COMATOSE PATIENT IN THE EMERGENCY ROOM

Thomas J. Preziosi, MD
Assistant Professor of Neurology
Johns Hopkins University School of Medicine

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, November 23, 1970	12:30 PM
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MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAYS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
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MEDICAL GRAND ROUNDS
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DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Osteoarthritis of the Knee

RENATO S. LAPIDARIO, MD
Assistant Professor
Division of Orthopaedic Surgery
University of Maryland Hospital
Baltimore

Osteoarthritis is primarily a process of degeneration of articular cartilage.[1] Degeneration causes incongruity of the previously smooth joint surfaces. Motion in the involved joint produces friction, flaking, fibrillation, and shedding of pieces of cartilage, which in turn irritate the synovial membrane. The cause of pain in osteoarthritis is not understood. Some investigators feel that it is produced by the reaction taking place in the synovium. Venous congestion and capsular fibrosis may contribute. As the process of degeneration continues, the cartilage is worn down. This exposes the subchondral bone to unusual pressure which responds by new bone formation. Marginal lipping or osteophyte formation results. Several areas of synovial membrane may undergo metaplasia to form cartilaginous or osteocartilaginous bodies. This is one source of loose bodies; another is fracture of marginal osteophytes. The process also affects the menisci, making them susceptible to injury.

With advancing age, degeneration occurs in almost all supportive structures, but the degree varies in different individuals and in different joints. Knees are more commonly affected by degenerative changes than other joints in the body.[2]

There are several factors that can cause or accentuate degeneration:

1. **Trauma:** This may be in the form of a direct external blow or indirect trauma as repeated displacements of loose or torn menisci, joint mice, and fractures. Irregular joint surfaces or loose bodies damage the articular surfaces. The pressure of carrying a heavy load, as when the patient is obese, also has a deleterious effect on the joint.

2. **Concentration of Pressure Load:** Normally in weight bearing, pressure forces are evenly distributed over the articular surfaces. When deformity exists, as in genu valgus or varus, the pressure forces are concentrated over a smaller area and degeneration occurs in these areas.

3. **Infection:** Proteolytic enzymes elaborated by infectious organisms destroy the cartilage, and irregularity of the joint surface results.

4. **Systemic Factors:** Any condition which causes damage to the joints, such as rheumatoid arthritis or ochronosis, can cause degeneration of the joint. Also, it has recently been shown that changes in the metabolic equilibrium may play a role in the susceptibility of the cartilage to osteoarthritis. For example, diabetic patients have been found to have an increased incidence and severity of degenerative joint disease of the usual types, in addition to the severe neuropathic changes seen occasionally in the ankle and the foot.[3] As observed experimentally, in mice made diabetic with anti-insulin serum, regressive changes were noted in the chondrocytes.

As mentioned earlier, the knee is more commonly affected by degenerative joint disease than any other joint. Usually, symptoms begin in the fourth or fifth decade of life or earlier if the causative factor is present at an early age. The patella is the site of the earliest and most profound changes in degenerative arthritis of the knee. Chondromalacia of the patella frequently starts the disease. The patellofemoral joint then becomes involved and erosion due

to friction follows. The irregular surfaces of the femoral condyle, in turn, damage the tibia.

Clinical Features

The patient complains of aching pain when moving and bearing weight, which is usually relieved by rest. Stiffness may be encountered after rest and freer movement is obtained with activity. The stiffness usually is relatively short in duration. Painful creaking and grating on active motion about the patella is an early finding. It is increased by any activity requiring contraction of the quadriceps, as in going up and down the stairs and arising from a sitting position.

Objectively, there is tenderness about the joint margins where the inflamed synovium protrudes, or over the lower margin of the patella. Crepitus at the under surface of the patella is common. If an effusion is present, the patella may be floating and crepitus may not be elicited. The fluid shows normal cytological and chemical findings, although it may contain numerous fragments of cartilage. Muscle atrophy, particularly of the quadriceps, is common due to disuse. In chronic cases, the bony margins are deformed and enlarged and range of motion is greatly reduced. Fixed flexion deformity is also usual. Involvement of the medial or the lateral tibiofemoral compartment will result in either a genu varus or valgus deformity. Greater pressure is exerted on the affected side and the ligaments on the opposite side are stretched. Locking may be caused by impingement of a hypertrophied synovium, displacement of a torn menisci, or a loose body trapped between the articular surfaces.

Radiological Features

In early cases, the roentgenographic appearance is usually normal. As the condition progresses, gradual joint narrowing is evident. With further degeneration, spurring or osteophytic formations at the joint margins are seen. Sclerotic subchondral bone and bone cysts appear in the subchondral portion of the bone at areas of maximum pressure. A gradual loss of height of the joint space of the lateral compartment produces a valgus deformity and the opposite deformity when the medial compartment is involved. The patella may be thickened and sclerotic. Loose osseous bodies may be seen. The patellofemoral interval is narrowed and the opposing surfaces are dense and irregular.

Treatment

Once degenerative changes are present, the condition is irreversible, although there are ways to stop further progression of the disease. In acute episodes, the patient should be put to bed. No weight bearing should be permitted and, if necessary, crutches should be used. The knee may be immobilized by a cast, a splint, or with Buck's traction. Heat, preferably moist heat, aids in relieving pain and muscular spasm. If all movement is painful, muscle setting and non-weight-bearing exercises should be employed until acute inflammation has subsided. These exercises can be performed without motion in the joint. No passive motion should be done. As long as joint pain, tenderness, and swelling are present, it is advisable to use immobilization so that muscular spasm is not aggravated. Following evidence of improvement, the period of splinting is gradually diminished. Active motion of the involved knee through as wide a range of motion as possible without pain, several times a day, should be performed together with active and resistive muscular exercises. Proper exercises, heat, and massage help to strengthen the muscles. Weight bearing is not started until acute inflammation has completely subsided and the muscles are strong enough to support the patient. If the quadriceps is still weak, a plaster cylinder may be used for support until full strength is regained.

In the presence of a flexion contracture, the deformity is corrected with the use of serial plaster castings or by traction. Under anesthesia, the knee is manipulated very gently, followed by application of a plaster cast. This is repeated as improvement occurs and physical therapy is instituted as soon as feasible. If no improvement is obtained with one manipulation, it is not wise to repeat the procedure. Skeletal traction or operation on the soft parts or upon the bones may be considered. Traction usually has fewer complications.

It is easier to prevent than to correct a deformity. Never place pillows under the knee for comfort as this is the most common cause of a flexion deformity. Resting in a chair for long periods should be discouraged. The use of night splints is very important since flexion of the knee is common during sleep. In cases where ankylosis is imminent, the part should be maintained in position of optimum function.

Even if the roentgenograms show evidence of severe degeneration, the knee may remain asymptomatic and functional, provided the quadriceps is strong and the joint is protected from trauma and abnormal strains. If the patient is overweight, weight reduction should be encouraged to lessen the load on the lower limbs. The early use of crutches will relieve some of the stress of weight bearing.

Drug therapy constitutes another part of the program. Medicines are only given to relieve the discomfort. At present, there is still no drug which can stop or reverse the anatomical changes of osteoarthritis. Acetylsalicylic acid is still the drug of choice. It is inexpensive, safe, and frequently as

effective as other drugs. Occasional patients may require antacids. For those allergic to aspirin, salicylamide, though less effective, may be used. Other drugs recommended for relief of pain are phenylbutazone, oxyphenbutazone, and indomethacin. These drugs are not without toxic effects. Patients should follow the recommended dosage schedule and proper precautions should be observed. Consideration should always be given to the contraindications to their use. Some patients, not helped by salicylates, may respond to one of these drugs. Usually, narcotics are not required. When such drugs are necessary to relieve joint pain, further investigation as to the etiology is mandatory.

A tender spot located about the joint interval may be injected with a local anesthetic. If improvement is not secured by a second treatment several days later, no further attempt should be made. Successful relief of symptoms has been attained by injection of steroids into the joint space. Its action is still not clear, but steroids are known to exert an anti-inflammatory action. Duration of relief of symptoms is variable from several days to months, with an average of about two weeks.

Some have recommended repeated injections as symptoms recurred,[4] but this should be viewed with caution. Lately, there have been several reports of complications following repeated injections at short intervals. One of these is the deterioration of the joint due to overuse, because of the masking of pain. Other complications reported are osteoporosis, aseptic necrosis, and secondary infection. When intra-articular steroid injections are used, the patient must be cautioned against excessive use of the injected joint. Injection should be given infrequently, should be performed under aseptic conditions, and the patient's condition should be followed closely.

Surgical treatment is indicated in some cases that fail to respond to conservative treatment. Occasionally, flakes of cartilage or loose bodies are present in the knee. When present, they may cause pain and locking and may lead to extensive degenerative changes. They should be removed surgically, preferably before degenerative changes become too severe. Also, degenerative changes may result from a torn or displaced meniscus and removal is indicated when this diagnosis is made. Localized patellofemoral degenerative arthritis without involvement of the rest of the joint is an indication for patellectomy or patelloplasty. In reconstruction of the patella, the osteophytes at the margin are excised and the patella is then rounded. The under surface is trimmed down to the bleeding bone and is made smooth. Some have used an interposition membrane such as fascia lata sutured to the under surface with good results.

When a knee joint is extensively involved, a general joint debridement is indicated.[5] This consists of removal of all the accessible synovial membrane, osteophytes, diseased cartilage, abnormal soft tissues, and sometimes the patella. This operation was described by Magnuson in 1941. He reported many good results. Since then, the operation has had a fairly wide acceptance. No cast is applied after the operation, although a compression dressing is used. Quadriceps setting exercises are started as soon as possible and active exercises are started a few days later. The physiotherapy should be continued under the guidance of the physician and the therapist until maximum benefit is obtained.

If osteoarthritis of the knee is confined mainly to one tibiofemoral compartment and the range of motion is 90 degrees or more, it can be treated safely and reliably by a proximal tibial osteotomy.[6] Some surgeons prefer the distal femur as the site of the osteotomy. With involvement of one tibiofemoral compartment, there is usually a valgus or varus deformity of the knee. On weight bearing, greater pressure is exerted on the side of the knee that is mainly affected, and the ligaments on the opposite side are stretched. Proximal tibial osteotomy corrects the angulation and the joint is realigned, so that on weight bearing, the pressure is equally distributed throughout the joint. Excessive stress on the collateral ligaments is relieved.

If the joint is severely involved or the operations mentioned above have failed, arthrodesis of the knee is indicated. This is the only procedure that can be expected to permanently relieve pain and insure stability if marked deformity is present. It has the added advantage of early ambulation.

Some patients prefer to be spared arthrodesis, especially if one knee has already been stiffened. In this instance, arthroplasty may be used. This may be in the form of metallic replacement of the upper tibial surface, a mould arthroplasty of the distal femur, or the use of a total knee prosthesis. There are two types of tibial plateau prostheses, one designed by McKeever which has a T-shaped anchoring device, and the other by McIntosch which is D-shaped and comes in various sizes and thicknesses. The McIntosch prosthesis is best used when there is bone and cartilage involvement with loss of the height of the tibial plateau. The McKeever device is more appropriate when there is cartilage destruction only. Metallic devices have produced good results in some patients and poor results in others.

Summary

1. For acute episodes of osteoarthritis of the knee, bed rest, immobilization, moist heat, and muscle setting exercises are indicated.

2. Drug therapy is considered an adjunct in the treatment program.

3. It is easier to prevent a deformity than to correct one.

4. Surgery plays an important role and is often used to restore function.

REFERENCES

1. Sokoloff, L.: "The Pathology and Pathogenesis of Osteoarthritis," in Hollander, J. L. (ed): *Arthritis and Allied Conditions,* ed 7, Philadelphia: Lea & Febiger, 1966, pp 849-869.
2. Turek, S. L.: *Orthopaedics,* ed 1, Philadelphia: J. B. Lippincott Co., 1959.
3. Moskowitz, R. W., et al: Current Concepts of Degenerative Joint Disease, *Bull Rheum Dis* 17:459-464, 1967.
4. Abrams, N. R.: "Treatment of Osteoarthritis," in Hollander, J. L. (ed.): *Arthritis and Allied Conditions,* ed 7, Philadelphia: Lea & Febiger, 1966, pp 886-895.
5. Isserlin, B.: Joint Debridement for Osteoarthritis of the Knee, *J Bone Joint Surg* **32B**:302-306, 1950.
6. Jackson, J. P., et al: High Tibial Osteotomy for Osteoarthritis of the Knee, *J Bone Joint Surg* **51B**:88-94, 1969.

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Examination of Sputum Cells

Microscopic examination of fresh wet sputum can provide reliable information on the diagnosis and prognosis of chronic bronchitis, bronchial asthma, and asthmatic bronchitis. It should be done routinely for all patients with these obstructive pulmonary diseases.

In patients with sputum production as part of a disease, one can glean information pertinent to the abnormality through the intelligent examination of this material. Sputum always implies some abnormal process of the bronchopulmonary system and the cellular and noncellular components reflect the pathologic process.

After a minimum of experience in identifying the various leukocytes and mucosal epithelial cells in fresh wet sputum under the microscope, one can reasonably differentiate allergic from nonallergic inflammations. In the chronic "obstructive" bronchopulmonary diseases, one can differentiate chronic bronchitis (CB), chronic bronchial asthma (CBA), and chronic asthmatic bronchitis (CAB).

This report deals primarily with sputum cytologic examination in these chronic diseases. It should be kept in mind, however, that sputum examination supplements or reinforces other important diagnostic procedures, beginning with sound, thorough clinical evaluation, which includes roentgenographic studies and pulmonary physiologic testing as indicated. It is not a substitute for them.

Common Cells In Sputum

The more common cell types in sputum can be divided into those exfoliated from the bronchial epithelial layer, those arising from other pulmonary tissues, and those entering from the circulating blood. The numbers, types, and cytologic condition of the bronchial epithelial cells (BEC) reflect the abnormality of the bronchial mucosa.

Normally, the nuclei of all BEC's are ovoid to round, with a definite chromatin structure. Two nuclei may be seen in occasional cells.

The cytoplasm usually has a finely granular reticular texture. The basal BEC is small—usually about the size of the lymphocyte—and has the greatest nucleus-to-cytoplasm ratio. Its shape is generally ovoid, with a rather regular cytoplasmic border. Intermediate-layer BEC have a greater cytoplasmic mass with an irregular and more polygonal shape.

The columnar BEC that line the lumen are ciliated or, less commonly, the goblet type with its variably sized mucopolysaccharide vacuole. Both are roughly rectangular, often tapering to a long tail at one end. The nucleus often bulges out the cell membrane at this tapered end. The secretory system of the goblet cell is at the broader end, but may also bulge out the cell with its mucinous product.

The brush border of the ciliated BEC is also at this end, and the origins of the cilia just beneath the cell membrane appear as a dark line. The cilia themselves are very delicate, hair-like structures about 5μ to 7μ long in these unfixed preparations.

Local cells of the reticuloendothelial system are seen in the sputum and are an index of the host's cellular resistance. The presence of alveolar macrophages or histiocytes in a specimen is the best assurance that it arises from the lower respiratory system.

Lymphocytes and monocytes in small numbers appear fairly regularly in sputum.

Often, material of unknown composition may be seen in the noncellular part of the sputum. The ab-

Sanford Chodosh, MD, The New England Journal of Medicine, *April 9, 1970 (Vol. 282, No. 15).*

sence of nuclei and the bizarre "plastic" shapes that this material assumes separates it morphologically from cellular structures. This material is often referred to as "myelin degeneration".

Cells similar to histiocytes are frequently seen with a nucleus resembling that of a blood monocyte, from which it probably transforms. Plasma cells that are seen in sputum possess the round, eccentric nucleus with the characteristically dense chromatin, without the expected spokewheel effect.

Leukocytes from the circulating blood usually comprise the majority of all sputum cells and are a direct measure of the nature of the inflammation.

Cells in these wet preparations are seen in three dimensions without the artifact of fixation, so reorientation to this different perspective is necessary.

Included are the polymorphonuclear neutrophil (PMN) and the similar polymorphonuclear eosinophil (PME) cells.

In chronic bronchitis (CB) bronchial epithelial cells (BEC) may comprise 5% to 15% of all cell types. Usually occurring singly, most show pyknotic degeneration. The cytoplasmic mass is often reduced. Bacteria are occasionally seen in the cytoplasm.

The basal BEC with darker nuclei are smaller and may have crinkled-cell membrane. The intermediate BEC are difficult to differentiate from pyknotic basal types. The ciliated BEC are small with dark nuclei. Cilia are rarely present but the basal plate of cilia remains.

In stable CB, histiocytes may comprise 5% to 20% of all cell types; in acute exacerbation they may drop to below 5%. Often yellowish-brown in color, histiocytes are commonly seen with ingested particles of dust, bacteria, and lipids.

The blood-transported PMN may comprise 75% to 95% of all cell types, whereas PME may comprise less than 2%.

Usually there is a 1% to 2% concentration of monocytes, though it may rise to 5% to 15% while histiocytes are rising.

In chronic asthmatic bronchitis (CAB) tissue and blood cellular composition is most often the same as in CB, though some swollen BEC may be seen and the level of PME may rise to between 5% and 20%.

In chronic bronchial asthma (CBA) BEC may comprise 10% to 30% of cell types. Though single BEC are often seen, large clusters (Creola bodies) are more common during acute exacerbation. Hydropic degeneration (swelling) distorts the definition of the original morphology. Cytoplasm and nuclei of both basal and intermediate cells may be swollen.

Though cilia is usually present on swollen ciliated BEC, ciliacytophoria with loss of cytoplasm is often seen. Some goblet cells can be identified, though swelling of these cells often obscures structure.

In stable CBA, the histiocytes may comprise 10% to 50% of all cell types while they may drop to 5% to 10% during acute exacerbation. Usually yellowish-brown color is not seen, although crystallized yellowish particles are often seen in the recovery period of an acute CBA attack. Clear vacuoles are common in cytoplasm.

Blood transported PMN may comprise 2% to 30% of the total cell types; PME, 22% to 90%. (Charcot-Leyden crystals may be plentiful as well as free eosinophil granules.)

Requiring only a few minutes, microscopic examination of fresh wet sputum preparations should be a standard laboratory procedure in the initial and subsequent evaluation of patients with chronic obstructive pulmonary diseases.

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Maryland Association of Medical Assistants

The Tenth Annual Convention of the Maryland Association of Medical Assistants was held on April 4-5, 1970 at the Holiday Inn Downtown. The featured speakers were William DeMaria, MD, Assistant Dean of Duke University Medical School; Mrs. Ruth Dize, President of the American Association of Medical Assistants; and Ronald Kornblum, MD, Assistant Medical Examiner for the State of Maryland.

Following an afternoon educational session and a banquet, Mrs. Dize installed the following officers of the Maryland Association of Medical Assistants:

President: Mrs. Jean Subock, of Annapolis (Baltimore Chapter)

Vice-President: Mrs. Frances Whittaker, of Rockville (Montgomery Chapter)

President-Elect: Mrs. Mabel Young, of Cumberland (Allegany Chapter)

Recording Secretary: Miss Sandra Orrison, of Wheaton (Montgomery Chapter)

Corresponding Secretary: Mrs. Ann Shultz, of Baltimore (Baltimore Chapter)

Treasurer: Mrs. Mary Minnick, of Cumberland (Allegany Chapter)



Mrs. Jean Subock (left) was recently installed as president of the Maryland Association of Medical Assistants. Miss Barbara Daniel (right) is immediate past president of the association.

The Tenth Semiannual Meeting of the Maryland Association of Medical Assistants was held in Ocean City on September 12, 1970. The convention activities were held at the Ship's Cafe, beginning with registration at 10 AM, followed by the business meeting.

The featured speakers for the afternoon educational session were Newland Day, MD, an internist from Baltimore who spoke on medicare. Theodore Kardash, MD, then spoke on abortion.

A unique addition to this year's semiannual meeting was an auction. Members of the association made articles to be auctioned, and Mrs. Lillian Burford, a charter member of the association, served as auctioneer.

The evening festivities began with a cocktail party on the terrace of the Ship's Cafe, followed by a banquet. The Master of Ceremonies for the evening was David Gilmore, MD, of Salisbury.

The programs for the convention were generously contributed by the Maryland Medical Service.

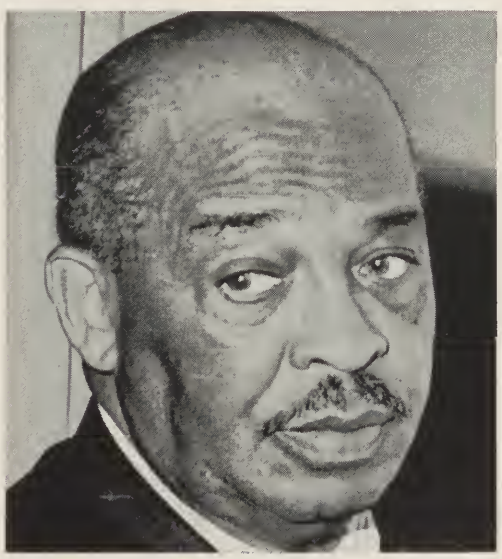
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Baltimore Association of Medical Assistants

The speaker at the April meeting of the Baltimore Association of Medical Assistants was Andre V. Fesus, MD, whose lecture was entitled, "Vietnam as Seen by an Ophthalmologist". The lecture was accompanied by slides taken in Vietnam by Dr. Fesus earlier this year.

In May, the members of the Baltimore chapter entertained their bosses at the annual Bosses Night held at the Eastwind. The highlight of the evening was a skit presented by several of the members entitled "Laugh Out-Smash In".

The June meeting featured Louis E. Harmon, MD, as guest speaker. Dr. Harmon spoke on basic and general care of the skin, including proper shaving habits for the men, and a discussion of acne for adults as well as teen-agers.



Dr. Harmon

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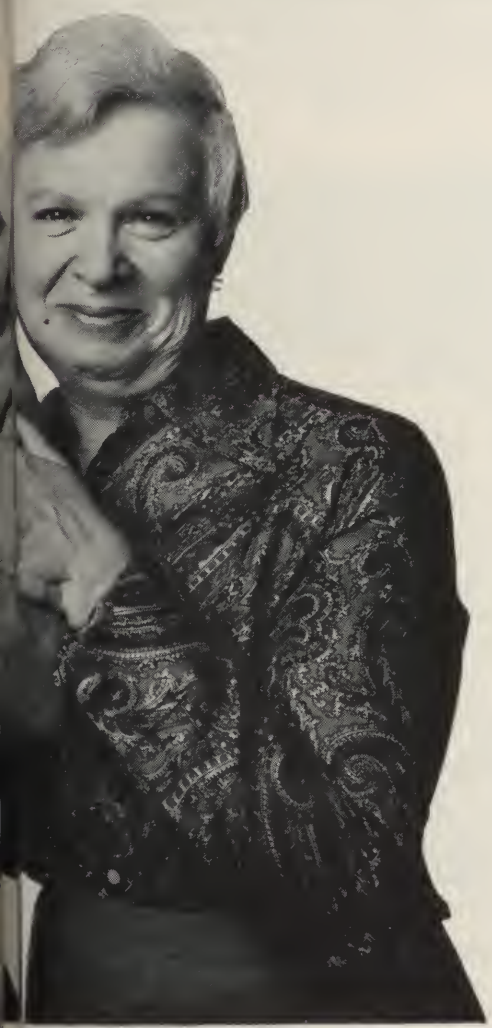


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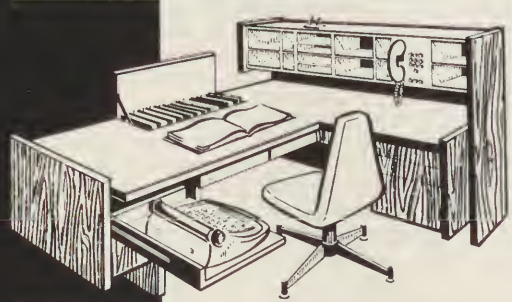
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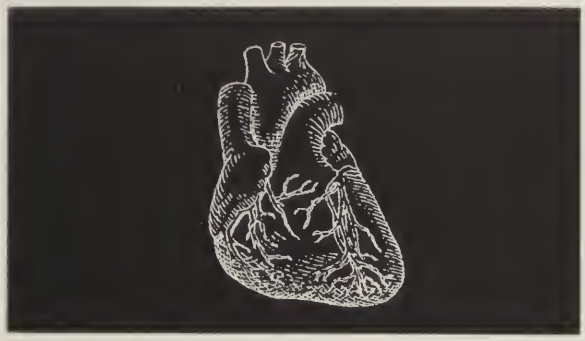
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MIRIAM L. COHEN, MD, EDITOR

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the heart page

Diagnosis of Hyperlipidemia

SIMEON MARGOLIS, MD
Associate Professor of Medicine
Johns Hopkins University School of Medicine
Baltimore

An elevation of serum lipid levels has been clearly identified as an important "risk factor" associated with the increased rate of development of coronary heart disease. The results of many prospective population studies, including the well-known Framingham study, have unequivocally shown that elevated cholesterol levels are associated with a greater risk of coronary heart disease. More limited studies indicate that hypertriglyceridemia also predisposes subjects to coronary heart disease.

In addition to the danger of accelerated atherosclerosis, hypertriglyceridemia has been recognized as a cause of acute pancreatitis. Careful scrutiny of serum lipid levels is an important part of the diagnostic evaluation of patients with pancreatitis, especially when recurrent attacks occur in patients who do not overindulge in alcohol.

Because of the serious consequences of premature coronary heart disease and the availability of effective therapy for most patients, a strong argument can be made for obtaining screening tests of serum lipids in all patients. At the very least, lipid studies should be done on all patients with xanthomata, hypertension, obesity, diabetes, premature coronary or peripheral vascular disease, or a strong family history of arteriosclerotic vascular disease.

All serum lipids are transported in the blood as a part of four complex proteins: α, β and pre-β-lipoproteins, and chylomicrons. Hyperlipidemia occurs when the concentration of one or more of these lipoproteins is increased. Thorough evaluation, therefore, requires not only routine lipid analyses (cholesterol and triglycerides), but also a determination of which lipoprotein is responsible for the hyperlipidemia.

Fredrickson and co-workers have delineated five types of hyperlipoproteinemia based on separation of the serum lipoproteins by paper electrophoresis:

Type	Plasma lipid fraction elevated	Lipoprotein abnormality
I	Triglycerides	Chylomicrons present
II	Cholesterol	β-lipoprotein increased
III	Cholesterol and Triglycerides	Presence of lipoprotein with β mobility, but pre-β density
IV	Triglycerides	Pre-β-lipoprotein increased
V	Triglycerides	Pre-β-lipoprotein increased and chylomicrons present

Although the frequency of familial hyperlipidemia is unknown, Types II and IV are fairly common disorders whereas the other three types are rare. Types II and IV are associated with a high risk of premature coronary heart disease. Peripheral vascular disease is often a complication of Type III. Slightly less than half the patients with xanthelasma and essentially all patients with tendinous xanthomata have Type II hyperlipidemia. Planar xanthomata in

the palmar creases are highly suggestive of Type III. Tuberous xanthomata can occur in Types II, III, and IV. Eruptive xanthomata may appear dramatically whenever triglycerides rise to very high levels, but disappear promptly as the glyceridemia is controlled.

Laboratory assessment of serum lipids should be done after the patient has fasted overnight but is otherwise on his usual diet. Frequently overlooked is the simple, but valuable screening procedure of examining serum for lactescence. The presence of lactescent serum on a fasting specimen is always abnormal and diagnostic of hypertriglyceridemia. Serum will consistently appear lactescent when triglycerides are greater than 500 mg%. Lactescence may also occur at lower triglyceride levels, particularly in the presence of chylomicronemia. More information can be obtained if the serum is placed in a refrigerator overnight before it is examined. Since both pre-β lipoproteins and chylomicrons tend to aggregate at low temperatures, lactescence will develop in most sera with triglyceride levels greater than 250 mg%. Hypercholesterolemia alone, in contrast, does not produce lactescent serum. The combination of a serum cholesterol determination and careful examination of serum for lactescence will detect more than 80% of patients with hyperlipidemia.

The refrigerated serum sample can also be used to make a tentative diagnosis of the type of glyceridemia. Chylomicrons float to the top of the sample as a creamy layer. Isolated chylomicronemia (Type I) presents a floating layer of fat on top of otherwise clear serum. In patients with Types III or IV hyperlipidemia, lactescence will remain evenly distributed throughout the serum. Hyperglyceridemia due to elevated levels of both chylomicrons and pre-β-lipoproteins (Type V) presents as a prominent creamy layer at the top of a sample which is also diffusely lactescent.

Chemical determinations should include both cholesterol and triglycerides. Phospholipids and total lipids give little additional information, and their routine determination is not warranted. Because serum cholesterol and triglyceride levels tend to increase with age in our population, it is advisable to compare the patient's results with values obtained from normal subjects in the same age range. Thus, in one group of subjects without metabolic disease, the upper limits of normal for serum cholesterol were 230 mg% in subjects below age 20, and 240, 270, 310, and 330 mg% in the 3rd, 4th, 5th, and 6th decades respectively. Triglyceride values were considered normal up to 140 mg% in patients less than 30 and up to 150, 160, and 190 mg% in the 4th, 5th, and 6th decades respectively. All subjects whose serum cholesterol or triglycerides exceeds these values should be considered as possible candidates for therapy. Ideally, at least three lipid determinations, obtained at weekly intervals, are needed to confirm the diagnosis and to establish a pre-treatment base line.

When serum cholesterol is high and triglycerides are normal, a diagnosis of Type II can be made with confidence. Hypertriglyceridemia requires further studies to determine the type of abnormality. Lipoprotein electrophoresis will often distinguish between the five types. Unfortunately, it may be difficult to properly type lipoprotein electrophoretic patterns run on paper strips. In one study, five independent observers completely agreed on the typing in only 6 of 20 different sera. Two new techniques, electrophoresis on cellulose acetate or on agarose gels, yield sharper lipoprotein bands and promise to provide better patterns for typing.

These procedures, which are generally available in most laboratories, will allow a firm diagnosis on most patients with hyperlipidemia. An occasional patient may need tests that can only be carried out in a special laboratory. For example, Type III can be suspected when a "broad beta band" is present on electrophoresis, but quantitative ultracentrifugation is needed to establish this diagnosis. Type I hyperlipidemia can be confirmed by demonstration of decreased serum lipoprotein lipase levels ten minutes after an intravenous injection of heparin.

In addition to its occurrence as a primary inherited disorder, hyperlipidemia may present as a complication of the following conditions: diabetes, pancreatitis, nephrotic syndrome, chronic renal failure, obstructive liver disease, myxedema, excessive alcohol intake, pregnancy, use of oral contraceptives, glycogen storage disease, and multiple myeloma. Secondary hyperlipidemia may present as any of the five types, but Type IV is most common. Since treatment of the underlying disorder in such patients may return serum lipid values to normal, appropriate studies should be carried out to eliminate these conditions as a possible cause of the hyperlipidemia.

Although severe degrees of hyperlipidemia are invariably the result of a metabolic abnormality or are secondary to some demonstrable disease, modest elevations of serum lipids may occur in subjects who ingest large amounts of calories or animal fat. Such diet-induced hyperlipidemia is more frequent in countries with a high standard of living. In general, the hyperlipidemia in such subjects responds in a most gratifying manner to dietary measures.

Finally, since all types of hyperlipidemia may be genetically determined, family members, especially children, should be screened for elevated serum lipid levels so that treatment can be initiated before irreversible vascular changes occur. Familial Type II disease can be detected in affected children shortly after birth. In contrast, Type IV hyperlipidemia is often not manifest until the late teens or early twenties.

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Meeting the Challenges of Public Health in Baltimore City

JOSEPH GORDON
Director
Bureau of Health Information
Baltimore City Health Department

The Baltimore City Health Department has met the challenging changes of the sixties through progressive programs in every public health field. Not only has the department provided more health services than ever before in Baltimore's history, but it has provided the city's residents with greater opportunities for health improvement through expanding its preventive, medical, and environmental programs.

Maternal and Child Health

In the field of maternal and child health, the city led the nation in establishing the first comprehensive maternity and infant services project sponsored with federal and matching funds. The project now provides quality care and guidance to one third of the city's expectant mothers. In 1969, some 5,350 mothers (from a total of 16,196 recorded births) received medical examinations, dental care, nutrition guidance, and assistance with social and delivery problems at the Baltimore Maternity Center at 211 W. Lombard Street, and in district clinics.

Many of Baltimore's health and social problems, and especially those of children, stem from the family's inability to nurture and foster a healthy family unit. In an attempt to correct this, a sizable $400,000 grant was obtained from the U.S. Children's Bureau in 1969 to increase available family planning services in the city. These services are being directed toward planning the kind of family that will give all members opportunities for success and happiness in life—not drudgery and despair as has too often been the case with large and unwanted families in Baltimore.

In the past five years the Maternity Project, which opened in 1965, has provided services to 27,931 maternity patients; 28,000 infants during their first year of life; and 17,685 patients for family planning services. The aim for earlier registration of pregnant women, a most important factor in maternal and infant deaths, is beginning to be a reality. In 1965, only 9% of the patients registered in their first trimester. In 1969, through expanded efforts, 35% to 40% of the patients registered in their first trimester. The number of unregistered patients at Baltimore City Hospitals declined from 70% in 1964 to 13% in 1968, which shows that the efforts to reach the "unreachable" are paying lifesaving dividends in better medical care.

To meet the health needs of children after birth, the City Health Department in 1964 and 1965 conceived a plan to provide free comprehensive services, including dental care, for needy children through age 18. This project materialized into the new Comprehensive Health Services for Children and Youth Projects in cooperation with five Baltimore hospitals. More than 30,000 youngsters and their families now benefit from this health program which provides both preventive and treatment services through funds from the Children's Bureau. In addition, some 30,000 preschoolers each year receive health services in 70 weekly well-baby clinic sessions in neighborhood areas throughout the city. At these sessions, parents receive the latest health information and guidance in child care.

The City Health Department also joined forces

with the Model Cities Agency and is providing iron-enriched milk to 2,000 eligible babies a year. In addition to providing more well-baby clinics, more child day care centers, improved preventive dental care, hearing aids, eyeglasses, and orthopedic devices, the department is offering a wide variety of general health services to Model Cities area residents.

With the help of the Community Action Agency and various neighborhood groups, the health department has made its services available to more and more needy people.

City children and their families have been the beneficiaries of the latest developments in preventive medicine. Successful city-wide vaccination programs have been conducted for the prevention of poliomyelitis, rabies, measles and, more recently in 1969 and 1970, German measles. These are now added to past programs aimed successfully at smallpox, diphtheria, whooping cough, and tetanus.

From the beginning, the goal of the health department has been to closely guard the city's health. Following studies that revealed poor nutrition among the city's poor, the department took immediate steps through the Mayor's Task Force on Nutrition and its own facilities to correct the deficiencies. Schools, city, state, and federal agencies, and a broad spectrum of voluntary groups cooperated in this major effort.

School health services involving the child, the curriculum, and the family are being expanded and modified so that city children will benefit and derive greater opportunities from the educational process. Teacher-nurse conferences, medical checkups, vision and screening tests, and aid to the handicapped through special services, are all a part of this program.

Tuberculosis

Perhaps the most noteworthy achievement in the continuing drive to conquer communicable disease is the dramatic 20% drop in active tuberculosis cases in 1969 compared with the previous year. The gains are the direct result of reinforced preventive and treatment programs involving case-finding, and the administration of new drugs for the treatment and prevention of active tuberculosis.

Chiefly for socioeconomic reasons, Baltimore has had the worst tuberculosis record of any large city in the country for many years. Past attacks have made but slight dents in the problem. However, a change was triggered by a federal report in 1963 by a special Task Force on Tuberculosis Control to the U.S. Surgeon General of the Public Health Service. The report, "The Future of Tuberculosis Control", surveyed the problem nationally and made recommendations. As a result, federal funds were made available for the expansion of local programs along certain specified lines. The city's tuberculosis laboratory was improved until it has become one of the best in the country; furthermore, an experienced tuberculosis controller was appointed in 1965 and the city program came to be recognized as the best in the region.

Other improvements included the following: the number of chest clinics in the city was increased from four to five; the hours in which service was available were increased from 48 to 172 a week; the scope of available drugs was widened; and the type and quality of service was improved so that patient cooperation substantially improved. By mid-1969, the program conformed in all respects to a set of performance standards set up by a representative committee sponsored by the U.S. Public Health Service. The overall results showed that patients could be discharged from hospital to clinic care at an earlier date with the knowledge that they would have continued treatment.

Concurrently, there has been a rapid expansion in the program of drug administration for the prevention of tuberculosis in high-risk individuals, and very recent expansion of this program into industry.

All these changes have had a spectacular effect on the tuberculosis situation. The most outstanding results show reductions of 10% and 20% in the tuberculosis incidence rates in 1968 and 1969, and a currently estimated projected reduction of 20% in 1970. A five-year statistical review has shown, among other changes, the following:

	1965	1969
Number of new cases	**705.0**	**500.0**
New active case rate	**76.8**	**55.1**
Clinic registrants	**27,809.0**	**38,383.0**
Clinic visits	**42,822.0**	**64,742.0**
Patients on drugs		
a) Therapy	**2,244.0**	**3,228.0**
b) Prevention	**516.0**	**3,930.0**
Patients on surveillance	**3,774.0**	**6,313.0**

The great increases in work loads have necessitated staff increases. This need has been principally met by the appointment of paramedical staff from the target areas who have been trained to take over work previously done by professionals.

The cost of the program over the five-year period has increased from $382,000 to $825,000. However, the shift of emphasis from hospital to community chest clinic has resulted in a greatly reduced expenditure for hospital care. This, on a cost effectiveness basis, has resulted in a saving of over $400 in hospital treatment for every $100 invested in outpatient care, with an overall improved efficiency as shown by the reduced rates and definite self-evident advantages to patients.

Mental Health

Taking a close look at the city's mental health needs in 1969, the Commissioner of Health formed

a Mental Health Advisory Council to study the city's programs and to recommend changes.

With additional funds from the State Department of Mental Hygiene through the Maryland Community Mental Health Service Grant for 1970, mental health services for children were expanded in the Eastern and Southeastern health districts. The Southeastern Mental Hygiene Clinic moved to new and larger quarters. The clinic is open daily, Monday through Friday, for treatment and consultative services for children with behavior problems who are referred by parents, schools, or community agencies.

In 1968, the Psychiatric Day Center, first established in 1962 as a community-based mental health facility for the prevention of hospitalization for those with emotional ills, was moved to new quarters at the North Charles Hospital complex. This mental hygiene day center, one of the first of its kind in the country, has become a showplace and training ground for visitors from other localities.

Alcoholism Programs

Alcoholism is now recognized as one of the major public health problems affecting our nation. It is estimated that there are some 80,000 to 100,000 alcoholics in Maryland and that about half of them reside in the Baltimore Metropolitan Area.

For many years, the only resource for the alcoholic was the fellowship of Alcoholics Anonymous and a few physicians who were interested in this disease. However, since 1935 when AA was founded by two recovering alcoholics, Dr. Bob and Mr. Bill W., the public has become more aware of this health problem.

In 1963, the Baltimore City Health Department opened its first clinic for the outpatient treatment of the alcoholic. A psychiatrist interested in alcoholism was appointed medical director of the clinic, which was housed in the Eastern Health District building. In 1965, the first Coordinator of Alcoholism Programs for Baltimore city was appointed to the staff of the Baltimore City Health Department. In 1967, an Alcoholism Center was established in a renovated three-story row house at 2221 St. Paul Street. The new building centralized the City Health Department's alcoholism services.

In addition to outpatient treatment for alcoholism, several other alcoholism programs have been initiated.

1. The Court Counselor program was instituted in May 1967 with one alcoholism counselor assigned to the Municipal Court of Baltimore City, Central District. There are now five such counselors in the Central, Northern, Eastern, Southern, and Northwestern districts. Although the state law was changed in 1968 and public intoxication is no longer a crime, there are still many alcoholics who come before the Municipal Court charged with misdemeanors. The Court Counselors provide consultation to the judges as well as the defendants in these cases.
2. In cooperation with the State Department of Probation and Parole, a Municipal Court Probation Alcoholic Rehabilitation Unit has been in operation since September 1965. This unit is housed in the Alcoholism Center.
3. With grant aid from the National Institute of Mental Health, a training program for alcoholism counselors was established at the health department's Alcoholism Center. Over 60 persons have been graduated from this program since its inception in 1967 and 55 are now employed in the field of alcoholism. The program is recognized nationally and is a needed answer to the problem of trained manpower to work with alcoholics.
4. The Alcoholism Center is an educational facility for the public in general. Seminars, lectures, and in-service training are provided by the staff of the center for professionals such as nurses, social workers, clergy, probation officers, and others who come into contact with the alcoholic. The center serves as the coordinating agency for the various programs that operate in the city and the state for alcoholics.

Geriatric Services

Newest of the health department's programs for the elderly is its Geriatric Evaluation Service. Inaugurated in May 1969, this project seeks to reduce admissions of Baltimore city residents aged 65 and over to state mental hospitals. With headquarters at the Good Samaritan Hospital, the new service is under joint sponsorship of the State Commission on the Aging and the Maryland State Department of Mental Hygiene. Funds for the first project year were made available on February 1, 1969 through Title III of the Older Americans Act and the State Department of Mental Hygiene.

A second program to aid the elderly is that of the Bureau of Special Home Services. This bureau, a delegate agency of the Community Action Agency, was established in the health department in 1968. Its purpose is to assist chronically aged persons of low income to obtain medical, social, and community services. During 1969, a total of 5,000 persons over 60 years old were aided by this bureau through medical-social evaluations and by visits and other assistance by specially trained health aides and volunteers. Services also included transportation and escort services, limited housekeeping assistance, and special social activities including boat rides, baseball games, and Christmas parties. Close cooperation is maintained with the Community Action Agency, the Model Cities Agency, and other official and private groups.

Medical Services

Neighborhood clinics bring needed health department preventive and treatment services close to the people that need them. These include seven prenatal clinics, seven family planning clinics, thirty-seven child health clinics, five immunization clinics, three venereal disease clinics, five tuberculosis clinics, twenty-nine dental clinics for children, and the mental health and alcoholism clinics mentioned above. In addition, some 300 public health nurses make about 80,000 home visits a year to examine newborn babies, to educate parents in child and personal health care, and to assist families with handicapped children.

As voluntary hospitals move out of the city and physicians emigrate to the suburban and county areas, a hard look is being taken at the city's treatment facilities. The City Health Department plans to contribute its energies or its services in meeting personal health care needs of residents. Such planning is underway with Bon Secours, Provident, North Charles General, Mercy, Sinai, and The Johns Hopkins hospitals.

The vital records unit of the department issued 37,370 transcripts of birth records and 74,495 copies of death certificates, while the health information services printed and distributed over 3 million pieces of health literature or other printed matter for department programs or individual and community use.

Sanitary and Environmental Services

A unique environmental health program, perhaps the first in the United States, is the City Health Department's Sanitary Enforcement Program. Begun in January 1969, the new division with a staff of 34 uniformed Sanitary Enforcement Officers maintains surveillance of exterior sanitary conditions in areas outside the inner city area. Within four districts, the enforcement officers visit residents and attempt to secure improvements and compliance with health ordinances and regulations through education. If this fails, enforcement measures are instituted. Since the onset of this program, over 681,000 inspections have been made and significant improvements noted.

Coordinating its efforts with the Sanitary Enforcement Division, the City Rat Eradication Program, a federally funded project, operates in the thickly-settled action area. Health aides, mostly inner city residents, operate from five trailers in strategic inner city locations. With emphasis on education, this program made 260,000 inspections in 1969, and at year's end had 374 city blocks under maintenance. Public Health Service rodent specialists have rated this program the best of its kind in the country. Both the Sanitary Enforcement Program and Rat Eradication Program involve community and neighborhood groups and closely cooperate with the Sanitation Division, the Police Department, the Community Action Agency, Model Cities, and other related city agencies.

The city's air pollution unit has been further reinforced by a $267,000 federal grant. The new funds will provide additional staff and new equipment. An important step forward was the Open Burning Ban Ordinance, made effective in 1968. Under the surveillance of the Bureau of Industrial Hygiene, local industry is making strong efforts to clean Baltimore's air. Moreover, the city is collaborating with county and state units in the designated Baltimore Air Quality Region established in August 1969.

The health department's efforts in the prevention of lead paint poisoning continue unabated. Throughout the sixties, there was a downward trend from 53 cases and four deaths in 1960 to 19 cases and no deaths in 1969. Low point was 1968 with only 13 reported cases.

Another accomplishment of the city's sanitary services is an outstanding record of 14 continuous years of milk production and processing without a single instance of unpasteurized milk offered for sale in the city.

Also noteworthy is the low number of food poisoning outbreaks in the city in recent years. The record shows only two food poisoning outbreaks in 1968 and 1969 involving 13 persons in all. Food control activities include the inspection of 10,000 food establishments in the city including wholesale, retail, manufacturing, and food departments of institutions. In 1969, nearly 250,000 lb of unwholesome food was condemned in the course of protecting the public from food-borne illness.

Medical Assistance Program—Medicaid

Medical services for the poor and medically needy of Baltimore city have always been a concern of city government. These needs of the poor have always been met through joint health and welfare service agencies. However, in 1966, with the establishment of the Maryland Medical Assistance Program, the city's medical care services were placed under state auspices with responsibility for efficient and effective administration, evaluation, and surveillance continued in the health department's Medical Care Services Section.

From 95,000 persons on the medical care rolls in 1965, the program had almost doubled to a total registry of 180,000 residents in 1969. Almost 2,500,000 coordinative efforts and supplies were furnished to both recipients and providers of the services. This figure represents a 20% increase in services with only a 10% increase in staff.

Recognizing the needs of the chronically ill, the health department instituted a new application evaluation service in July 1969 to aid the placement

of patients in nursing homes best suited to the patient's needs. In the first six months, more than 3,000 patients were added by the processing of applications in the Medical Care Services Section.

Camp Concern

As one of the agencies instrumental in the organization and administration of Camp Concern, the City Health Department devoted much time and effort to this summer day camp for disadvantaged youth held at the U.S. Naval Training Center in Bainbridge, Maryland. Close cooperation was maintained with the Department of Recreation in the development and evaluation of the program as well as in the conduct of its many health aspects. Approximately 15,000 youths have now participated in this unique experience which hopefully plays an important part in guiding youth into the channels of constructive citizenship.

Conclusion

The passing years have seen many changes in the City Health Department's efforts to guard the health of Baltimore's citizens. Continued emphasis must be and is being placed on the broad preventive measures. However, as the population and its health status evolves in a changing world of changing directions, the health department will be ready to take whatever steps are necessary, preventive or treatment, in carrying out its charge.

Finally, it should be emphasized that the health department's work could not be accomplished without the support and cooperation of the Medical and Chirurgical Faculty of Maryland, the Baltimore City Medical Society, the Maryland State Department of Health and Mental Hygiene, and the many other agencies, official and nonofficial, who, like the medical profession, are dedicated to improving the health of our citizens.

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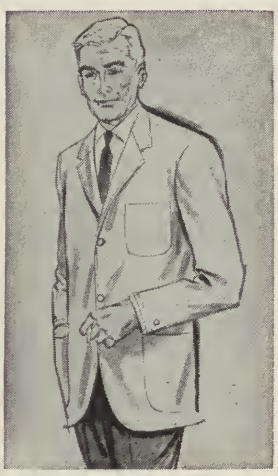
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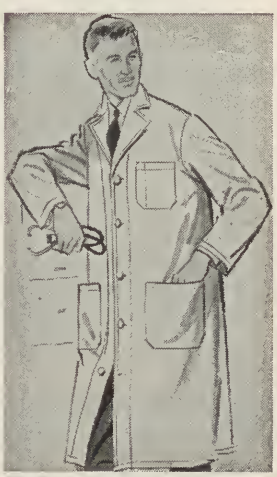
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library

Visit to Western Maryland

In an effort to acquaint myself with the librarians and others working in the libraries of Maryland's hospitals, I recently accompanied my husband, Gil Sanford, Associate for Research, Maryland Hospital Association, on an information-gathering trip to several Western Maryland hospitals.

We visited Garrett County Hospital in Oakland, Memorial Hospital and Sacred Heart Hospital in Cumberland, and Washington County Hospital, Western Maryland Hospital, and Brook Lane Psychiatric Center in Hagerstown.

In each hospital, I visited the library to discuss individual situations and problems with the librarian, or secretary, clerk, medical records librarian or any other person designated as librarian. At Brook Lane Psychiatric Center, the library staff included a very enthusiastic volunteer who also works in the Washington County Free Library. In all cases, everyone was anxious to learn how to improve their library collections, quarters, and services. In turn, I was interested in discovering how our interlibrary services could best serve the hospitals and their staffs. We also visited Frostburg State College, since we have a regular interlibrary loan service with them.

Possibly, I learned more about the hospital library situation in Western Maryland than any of those librarians whom I visited learned from me, but I believe that the rapport established between us was certainly beneficial.

* * *

As a reminder—the D. C. Area Medical Library Association meets in Baltimore on Saturday, October 24, 1970. Outstanding speakers will include Dr. Norman L. Stearns of the Postgraduate Medical Institute in Boston, Mrs. Mary Margaret Baxter of the SUNY network in Washington, D.C., and Mrs. Ada M. Lindsey of the Learning Resources Center at the University of Maryland. If you did not receive an announcement with a registration form, contact Miss Hilda Moore, Librarian, Health Sciences Library, University of Maryland, Baltimore, Md. 21201, or Mrs. Elizabeth G. Sanford, Librarian, Medical and Chirurgical Faculty of Maryland, 1211 Cathedral St., Baltimore, Md. 21201. Anyone interested in medical libraries is welcome to attend.

NEW ACCESSIONS—BOOKS

(Arranged by Author and Title)

Allan, Frank D.
Essentials of human embryology. 2d ed. New York, Oxford University Press, 1969.

American pediatric directory. 14th, 1970/71. A roster of pediatricians of the United States and Canada with complete professional biography. Knoxville, Tenn., Smith, 1969.

Barber, Hugh R.
Quick reference to ob-gyn procedures. By obstetrical and gynecological staff, Lenox Hill Hospital, New York. Edited by Hugh R. K. Barber and Edward A. Graber. Philadelphia, Lippincott, 1969.

Barnard, Christiaan N.
The surgery of the common congenital cardiac malformations. By Christiaan Barnard and Velva Schrire. New York, Hoeber, 1968.

Bowers, John Z.
Medical schools for the modern world. Edited by John Z. Bowers. Baltimore, Published for the Josiah Macy, Jr. Foundation by Johns Hopkins Press, 1970.

Bowers, John Z.
Western medical pioneers in feudal Japan. Baltimore, Published for the Josiah Macy, Jr. Foundation by Johns Hopkins Press, 1970.

Bradykinin and related kinins; cardiovascular, biochemical, and neural actions; proceedings of an international symposium on the cardiovascular and neural actions of bradykinin and related kinins held at Castel di Poggio, Fiesole (Florence), Italy, July 21-25, 1969. Edited by F. Sicuteri, M. Rocha e Silva and Nathan Back. New York, Plenum Press, 1970.

Brest, Albert N.
Hypertensive cardiovascular disease. Philadelphia, Davis, 1969. (Cardiovascular clinics, v. 1, no. 1)

Brussel, James A.
The physician's concise handbook of psychiatry. New York, Brunner/Mazel, 1969.

Cardiovascular therapy. Edited by Albert N. Brest. Philadelphia, Davis, 1969.

Chertok, Leon.
Motherhood and personality. By Leon Chertok with M. Bonnaud and others. London, Tavistock; Philadelphia, Lippincott, 1969.

Cole, Warren H.
Cole and Zollinger textbook of surgery. By Warren H. Cole and Robert M. Zollinger. 9th ed. New York, Appleton-Century-Crofts, 1970.

Conference on the History of Medicinal Drug Control, NLM, 1968.
Safeguarding the public. Edited by John B. Blake. Baltimore, Johns Hopkins Press, 1970.

Cooke, Robert E.
The biologic basis of pediatric practice. Edited by Robert E. Cooke. Associate editor: Sidney Levin. New York, McGraw-Hill, 1968.

Crelin, Edmund S.
Anatomy of the newborn. Philadelphia, Lea & Febiger, 1969.

Darby, Patricia.
Your career in physical therapy. By Patricia Darby and Ray Darby. New York, Messner, 1969.

Donáth, Tibor.
Anatomical dictionary with nomenclatures and explanatory notes. English ed. edited by G. N. C. Crawford. Oxford, Pergamon Press, 1969.

Dummer, G. W. A.
Medical electronic equipment, 1969-1970. Edited by G. W. A. Dummer and J. Mackenzie Robertson. Oxford, Pergamon Press, 1970.

Furman, Robert A.
The therapeutic nursery school. Edited by Robert A. Furman and Anny Katan. New York, International Universities Press, 1969.

Graves, Charles.
Invasion by virus. London, Icon Books, 1969.

Green, Richard.
Transsexualism and sex reassignment. Edited by Richard Green and John Money. Baltimore, Johns Hopkins Press, 1969.

Greenspan, Kalman.
Physiology review, 4th ed. Edited by Kalman Greenspan. Flushing, N.Y., Medical Examination Pub. Co., 1969.

Haller, J.
Deep thrombophlebitis. Philadelphia, Saunders Co., 1967.

Harris, Dale B.
Comparison of timed and untimed presentation of the Goodenough-Harris test of intellectual maturity. Washington, U.S. Health Services and Mental Health Administration, 1969.

Havener, William H.
Atlas of diagnostic techniques and treatment of intraocular foreign bodies. By William H. Havener and Sallie L. Gloeckner. St. Louis, Mosby, 1969.

International Congress of Neurological Surgery. 4th, New York, 1969.
Fourth International Congress of Neurological Surgery, Ninth International Congress of Neurology, Sept. 20-27, 1969, New York. Abstracts of papers, scientific exhibits, and motion pictures. Edited by Charles G. Drake and Roger Duvoisin. Amsterdam, Excerpta Medica Foundation, 1969.

Jasper, Herbert H.
Basic mechanisms of the epilepsies. Edited by Herbert H. Jasper, Arthur A. Ward and Alfred Pope. Boston, Little, Brown, 1969.

Johnson, Stephen L.
The history of cardiac surgery, 1896-1955. Baltimore, Johns Hopkins Press, 1970.

Joint Commission on Accreditation of Hospitals.
Standards for accreditation of hospitals plus provisional interpretations. Chicago, 1969.

May, Charles H.
May and Worth's manual of diseases of the eye. 13th ed. By T. Keith Lyle, Alexander G. Cross and Charles A. G. Cook. Philadelphia, Davis, 1968.

Mennell, John McM.
Foot pain. Boston, Little, Brown, 1969.

Miescher, Peter A.
Textbook of immunopathology. Edited by Peter A. Miescher and Hans J. Muller-Eberhard. New York, Grune & Stratton, 1968-69.

Morgan, Roy.
Marital status and living arrangements before admission to nursing and personal care homes. Washington, U.S. Health Services and Mental Health Administration, 1969.

Moser, Robert H.
Diseases of medical progress; a study of iatrogenic disease. 3d ed. Springfield, Ill. Thomas, 1969.

Neter, Erwin.
Medical microbiology. 6th ed. Philadelphia, Davis, 1969.

O'Malley, Charles D.
The history of medical education; an international symposium held Feb. 5-9, 1968. Berkeley, University of California Press, 1970. (UCLA forum in medical sciences, no. 12.)

Operative surgery, v. 1-14. 2d ed. Edited by Charles Rob and Rodney Smith. Philadelphia, Lippincott, 1968-70.

The **Pediatric patient, 1968.** Philadelphia, Lippincott, 1968.

Physical activity and aging; with special reference to the effect of exercise and training on the natural history of arteriosclerotic heart disease. Edited by D. Brunner and E. Jokl. Baltimore, University Park Press, 1970. (Medicine and sport, v. 4)

Physician's book compendium, 1969-1970. The medical book reference for physicians. Edited by Max Celnik. New York, Physician's Book Compendium, Inc., 1969.

Pickering, Sir George White.
High blood pressure. 2d ed. New York, Grune & Stratton, 1968.

Powers, Maryann.
The cardiac surgical patient; pathophysiologic considerations and nursing care. By Maryann Powers and Frances Storlie. New York, Macmillan, 1968.

Purkis, I. E.
Medicine in the university and community of the future; proceedings of the scientific sessions marking the centennial of the Faculty of Medicine, Dalhousie University, Sept. 11-13, 1968. Edited by I. E. Purkis and U. F. Matthews. Halifax, N.S., Faculty of Medicine, Dalhousie University, 1969.

Race, Robert R.
Blood groups in man. By R. R. Race and Ruth Sanger. 5th ed. Philadelphia, Davis, 1968.

Schultz, Richard C.
Facial injuries. Chicago, Year Book Medical Publishers, 1970.

Siegel, Rudolph E.
Galen on sense perception. Basel, Karger, 1970.

Sleep: physiology & pathology; a symposium. Edited by Anthony Kales. Philadelphia, Lippincott, 1969.

Te Linde, Richard W.
Operative gynecology. By Richard W. Te Linde and Richard F. Mattingly. 4th ed. Philadelphia, Lippincott, 1970.

Truex, Raymond C.
Human neuroanatomy. By Raymond Truex and Malcolm B. Carpenter. 6th ed. Baltimore, Williams & Wilkins, 1969.

Tuft, Louis.
Allergy in children. By Louis Tuft and Harry L. Mueller. Philadelphia, Saunders, 1970.

U.S. National Committee on Vital & Health Statistics.
Use of hospital data for epidemiologic and medical-care research; a report. Washington, U.S. Health Services and Mental Health Administration, 1969.

Valentine, Gordon H.
The chromosome disorders. 2d ed. Philadelphia, Lippincott, 1969.

Walter, Richard D.
S. Weir Mitchell, M.D., neurologist. Springfield, Ill., Thomas, 1970.

Wilder-Smith, A. E.
The drug users. Wheaton, Ill., Shaw, 1969.

Winter, Ruth.
Poisons in your food. New York, Crown, 1969.

Wyke, Barry D.
Principles of general neurology. Amsterdam, Elsevier, 1969.

The Year book of psychiatry and applied mental health. Chicago, Year Book Medical Publishers, 1970.

Yu, Paul N.
Pulmonary blood volume in health and disease. Philadelphia, Lea & Febiger, 1969.

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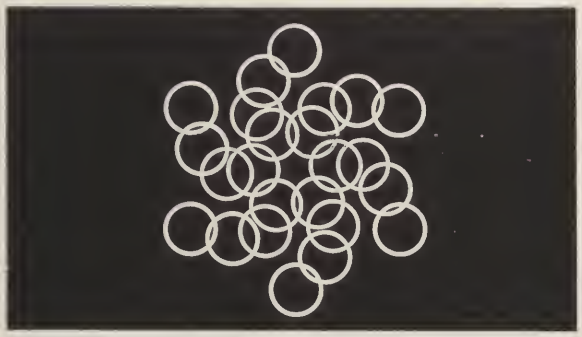
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Alcoholism: Diagnosis

The diagnosis of alcoholism often proves exceedingly difficult for a highly-skilled clinician, or it may be readily apparent to the most disinterested onlooker. Early in its course a high index of suspicion, whenever certain clues appear, will aid the physician in ferreting out additional information on which to base the diagnosis. Not infrequently, the identification will have been made beforehand by the patient's spouse, relative, or associate, who presents accumulated observations and conclusions to the physician for confirmation. It is unwise in any case to prematurely infer that the person is or is not an alcoholic. Rather, one should proceed as methodically as possible toward establishing the diagnosis in the usual manner through careful history, physical examination, and appropriate laboratory studies.

History

Because signs of physical decline are seldom observed before alcoholism is fairly well advanced, early diagnosis and subsequent appraisal of the stage or severity of the illness will depend to a large measure upon accurate historical information. Although there is unavoidable danger in generalizing to describe a "typical" history of the disease, it is apparent that a number of common factors are repeatedly observed. These warrant presentation to demonstrate points which may be critical to proper evaluation of the patient who uses alcohol.

The onset of alcoholism is usually sufficiently insidious and gradual to make it difficult to distinguish the alcoholic from the heavy drinker, although the distinction between the two can also be evident from the beginning. The alcoholic, as compared with the nonalcoholic, has greater emotional response to alcohol and attaches inordinate significance to it, often at the time of the first drink, and then progressively so as the illness develops. One of the earliest signs of alcoholism may be that the use of alcohol precedes, rather than accompanies, a person's having a good time, and that social events become occasions for him to continue to drink, and to excess. Alcohol gradually seems required for real pleasure or enjoyment, and he ensures having enough real pleasure or enjoyment by "fortifying" himself with alcohol before leaving for a party or a comparable function. Alcohol then becomes the goal of social activities, and soon he finds other reasons for using it, such as coping with stress and anxiety. The frequency and degree of his intoxication increase and are at times highly inappropriate to the circumstances. He may become severely intoxicated quite unintentionally, but with greater and greater frequency. He is likely to show irritation and annoyance with those commenting on his intake and associated behavior, especially if they express concern.

In the second major phase of advancement, the alcoholic begins drinking surreptitiously, faster and earlier, and becomes intoxicated regularly. Drinks are gulped down, while more (but less valid) reasons are given for "having a few". Along with his growing preoccupation with alcohol, he starts to feel unmistakable guilt, which leads him to make excuses and to "justify" his drinking. He typically becomes even more defensive about his drinking pattern, and often is openly hostile and angry when it is so much as alluded to. Not infrequently his own concern will have reached the point where he tries to regain control by changing brands or types of beverages, seeking other company, rationing his intake, or limiting his drinking to specific times of the day. He may even "swear off" to prove he can "take it or leave it". Unfortunately, at about this time he may try to

Excerpt from Manual on Alcoholism, *(c) 1968 by the American Medical Association: Reprint permission granted by the American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.*

achieve abstinence by substituting other drugs for alcohol such as barbiturates and other sedatives, or amphetamines and other stimulants. These he may take alone or concurrently, or combine them with alcohol.

As the illness progresses, so-called blackouts become a common phenomenon—episodes in which the alcoholic has temporary amnesia for various periods of time during which he has been drinking. These lapses are characteristically followed by feelings of considerable anxiety, concern, and guilt over what may have taken place. There may, however, be little more than mild annoyance at these gaps in memory. Irresponsible or expansive behavior and excessive emotionalism frequently are observed at this time, as the ego-damaging incriminations of others increase the alcoholic's self-doubts. Awareness of physical damage brought on by drinking, as evidenced by the blackouts, for example, may prove a major factor in his efforts to restore himself in his own or others' eyes, often through formulating great plans for the future. These plans seldom materialize, and this in itself contributes to his further emotional deterioration.

Next, the alcoholic loses control over his drinking and frequently drinks to a point of serious intoxication and stupor. Drinking no longer serves its original purposes but now gradually becomes an instrument of destruction. He begins to plan his life around alcohol, taking pains to guarantee a supply, seeking excuses to leave work or escape from others in order to maintain his intake. Supplementation with other drugs often increases. Not uncommonly, he drops old friends or quits employers, perhaps sensing their impending rejection and softening the blows by abandoning them first, replacing them with inferior substitutes. Marital and family problems are compounded, arrests for drunkenness or drunken driving may occur, and social, occupational, mental, and moral disintegration commonly take place as he seeks greater and greater isolation. Tolerance to alcohol is progressively lost, and the more serious physical complications of the disease often begin to predominate over the psychiatric and social ones. Finally, he "reaches bottom".

Physical Examination

Early in the course of the illness, few physical signs are attributed to alcoholism. At the other extreme, the examination probably will focus primarily upon those signs reflecting the complicating ailments and degenerative processes associated with advanced stages. Therefore, it is likely that in most instances the physician will not base a conclusive diagnosis of alcoholism upon physical findings alone. Certain observations, however, will prove substantially helpful in initially arousing his suspicions or perhaps in adding confirmatory evidence to historical facts. Eventually, they will be important in evaluating the degree of advancement or in detecting complications.

It is apparent that the patient who arrives at the office or hospital for examination and treatment with the odor of alcohol on his breath or in a state of intoxication should be suspected of being an alcoholic. The possibility of alcoholism is strongly suggested in the patient who is found to be drinking while hospitalized, as well as in others using alcohol under inappropriate circumstances.

Unusual anxiety, obvious moodiness, shyness, obsequiousness, over-compliance, and passive or overt hostility are by no means exclusive to the alcoholic or necessarily characteristic. Examination, however, may precipitate the appearance of these features and thus reveal the possible presence of serious emotional disturbance, perhaps associated with alcoholism. Other behavior, or aspects of personal appearance incongruous with the patient's background may also be signs of alcoholism.

Unexplained coarse tremor of the hands is often an early clinical manifestation of the illness. Persistent vascular dilatation in the face, especially around the nose, or a palpable but non-tender liver, later suggest physical deterioration associated with excessive intake of alcohol over a period of time.

In the advanced state, one may see multiple fresh and partially healed contusions and abrasions over the extremities, head, and shoulders. The patient frequently is unable or unwilling to explain that these are the result of numerous falls during periods of intoxication. Serious head injury also can occur in this way, and may be seen as the presenting problem.

Some clinicians describe the eventual development of a characteristic "alcoholic facies", with puffiness and deep lines around the eyes, pallor, and vascular engorgement. Malnutrition, associated metabolic and dietary deficiencies, and peripheral neuropathies usually are found late in the course of alcoholism. Finally, the signs of delirium or of a chronic brain syndrome may be observed.

Laboratory Studies

While blood alcohol levels ordinarily will be diagnostic only of the degree of intoxication, other laboratory findings will be helpful in evaluating the alcoholic patient's general physical condition. A number of studies obviously are useful in determining how seriously ill he may be. Others will help define complications and measure their response to treatment.

Even though a person may have been drinking or is possibly alcoholic, stupor or coma can be due to head injury, diabetes, hyperinsulinism, or hemorrhage, or to other drugs. X-rays and other appropriate laboratory procedures are needed to establish the cause and institute proper remedial measures. Electrolyte determinations will help define need for correcting existing imbalances.

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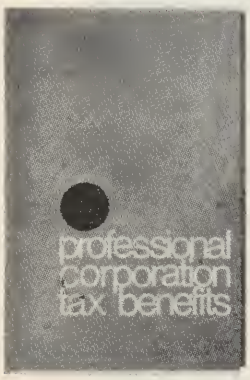
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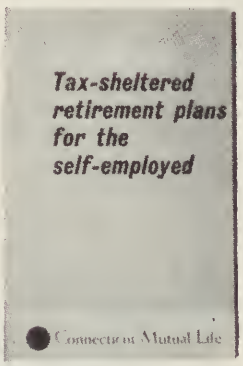


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Maryland's Mental Hospitals Six Years After Desegregation

Admissions to Maryland's four major mental hospitals were, for the first time, placed on a regional basis in January 1963. The majority of all persons admitted to each of these facilities since that time have been white. However, this desegregation plan did not provide for the transfer of patients already in residence. Since 3,152 (or 38.1%) of those hospitalized at the beginning of 1963 were still under care in the same facility six years later, integration has been gradual and concentrated primarily in short-term active treatment areas. Latest available data (as of December 31, 1968) indicate that 52.6% of all nonwhite patients and 9.6% of all white patients are at Crownsville. Comparable figures for those admitted since January 1963 are 27.1% and 18.9%, respectively.

PERCENT OF NONWHITE PATIENTS IN EACH HOSPITAL

DATE	TOTAL	CROWNS-VILLE	EASTERN SHORE	SPRING-FIELD	SPRING GROVE
DEC. 31, 1962	22.6	100.0	0.0	0.0	0.0
DEC. 31, 1963	23.4	85.9	7.6	6.2	4.5
DEC. 31, 1964	23.9	78.2	10.7	8.9	7.1
DEC. 31, 1965	24.9	73.4	14.9	11.5	8.9
DEC. 31, 1966	25.5	71.0	16.6	13.2	9.9
DEC. 31, 1967	25.6	69.4	18.2	14.3	9.8
DEC. 31, 1968	25.3	65.2	19.7	15.2	14.1

Prior to this policy change, white admissions had, in effect, been on a regional basis (to three hospitals) while nonwhite admissions had been limited to one facility (Crownsville). The revision thus brought mental hospitals considerably closer to nonwhite residents in some areas of the state. As a result, although both the number of white and nonwhite admissions have continued to increase, the latter figure has been rising at a faster pace. Latest available data (for the year ending June 30, 1969) indicate that 30.4% of all patients admitted to the above facilities were nonwhite as compared with the 26.2% reported six years earlier. However, this change has been selective and concentrated among the nonpsychotic. For example, among patients admitted for psychoneurotic and personality disorders, the percent of nonwhite patients increased from 20.8% to 25.8% during this time period. Similarily, while 20.1% of those admitted for alcoholism before desegregation were Negro, this is now 28.7%.

Proportionally, nonwhite state hospital admissions have continued to be twice as frequent as white. In part, this is related to the concentration of nearly half of all Maryland Negroes but less than 10% of the state's white residents in Baltimore's inner core slum areas where rates of most types of treated mental illnesses and of other public health problems are substantially above average. In part, also, this reflects the much greater use of alternative psychiatric services (particularly privately-operated hospitals and private practice) by the white middle class. State hospitals are only one of a variety of psychiatric resources available to the community. Desegregation of these facilities by itself cannot, therefore, necessarily be expected to provide the opportunity for adequate care to meet the needs of all population segments. That is, programs to meet these issues and problems must involve all available resources and services and cannot be limited to state-operated facilities alone.

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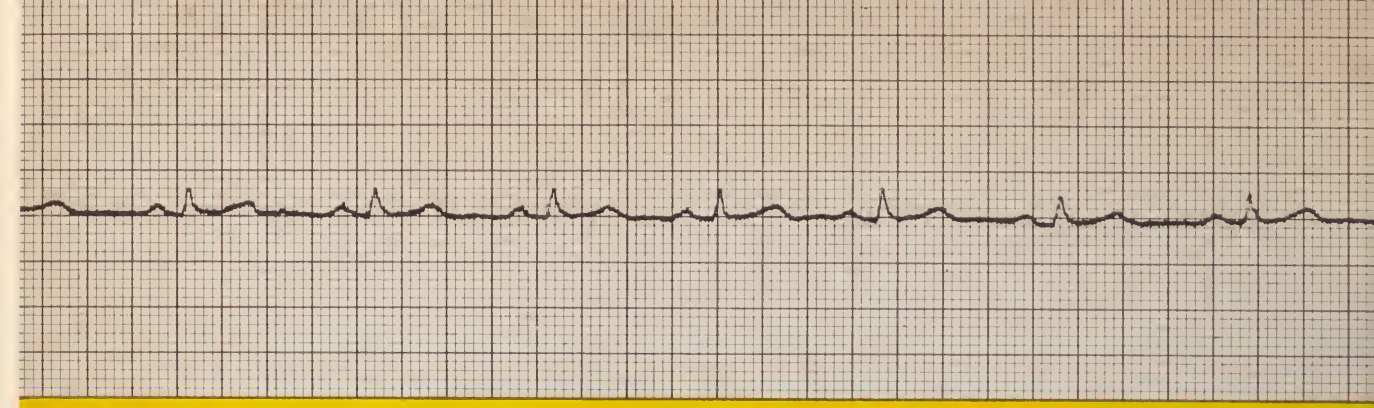
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

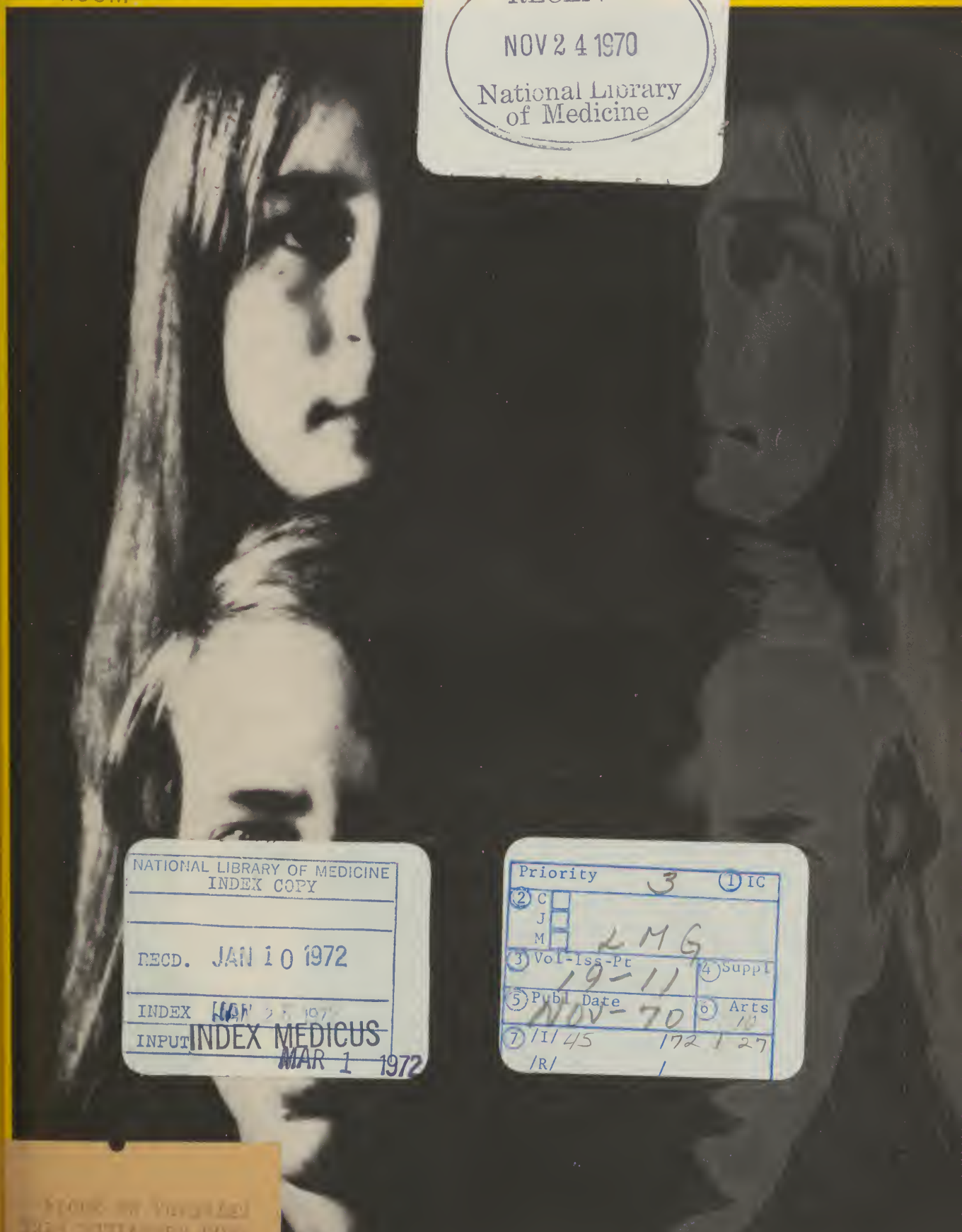
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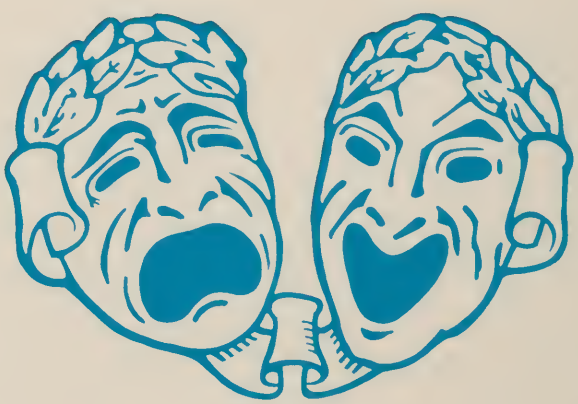
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(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.



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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

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CONTENTS:

Editorial—"Singing is Better Than Any Dope" 61

Why People Take Drugs: Escape and Search, Leon Wurmser, MD 62

"In a world that is constantly changing, man is seeking real meaning in life. He may use drugs in a very genuine attempt to cope with the disillusionment and despair that faces him. His quest for real meaning all too often ends in slavish entrapment and a new lie."

Treatment of the Opiate Addict in Maryland: Does the General Hospital Have a Role? Joseph I. Berman, MD 65

"The belief that programs developed by the Drug Abuse Authority provide the best possible care for the addict raises the question of the role of the general hospital in the rehabilitation and treatment of the opiate addict."

Introduction—Drug Abuse: The Dangers and Responses, Russell S. Fisher, MD, Louis J. Kolodner, MD 68

Drug Abuse and the Courts, The Honorable David Ross 70

"There are essentially two ways that drug abusers and drug addicts come before the criminal courts. Addiction itself is not a crime and, under our Federal Constitution, the states are prohibited from making it a crime."

The Addict, Rehabilitation, and the Law, Steven V. Sklar, LLB 72

"Drug abuse is a primary cause of the increase in the crime rate today. It is estimated by statisticians and by judges in the Baltimore area that 50%, if not more, of all crimes committed in the area are motivated by drug addicts in need of funds to support their habits."

Methadone Maintenance Treatment Program, Harvey Gollance, MD 74

"Drug addiction has reached epidemic proportions in New York city and in other sections of the United States as well. An effective treatment for severe heroin addicts known as the Methadone Maintenance Treatment Program has been developed at Rockefeller University and has continued in a greatly expanded program at the Beth Israel Medical Center in New York."

The Communication Gap and the Drug Problem, Neil Solomon, MD, PhD 78

"I am here to make a plea for communication—the kind of communication that should exist between patient and physician, between teacher and student, between parent and child, and between husband and wife, but does not. This lack of real open-door communication leads to drug use."

Panel Discussion—Drug Abuse: "The Dangers and Responses" 80

DEPARTMENTS:

Library Page—Meetings, Activities and Acquisitions 25

Your Medical Faculty at Work, John Sargeant 82

Tuberculosis—Genetic and Environmental Determinants of Chronic Obstructive Pulmonary Disease 85

Rehabilitation Notes—The Effectiveness of Vocational Evaluation in the Rehabilitation Process, Charles Smolkin, MEd, AGS, Justina Twilley, B. Stanley Cohen, MD 95

Baltimore City Health Department—Geriatric Evaluation Service Progress ... 99

Heart Page—Treatment of Hyperlipidemia, Simeon Margolis, MD 101

Maryland State Department of Health and Mental Hygiene—Care of the Aged, Neil Solomon, MD, PhD, Matthew Tayback, ScD; **New Programs for the Mentally Retarded; The Care of the Mentally Subnormal** 105

Alcoholism Page—The Maryland Alcoholism Program, Maxwell N. Weisman, MD 109

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ON THE COVER: This month's cover photograph, for the drug abuse issue, was once again contributed by W. Brooks Short, III, a student at Towson State College.

Doctors Take Note 5

Executive Director's Newsletter 9

Sports Seminar Program 13

Component Society News 17, 49, 91

Annual Meeting Art and Hobby Exhibit Form 19

Scientific Exhibit Form 28

The Month in Washington 31

Medical News 37

Woman's Auxiliary 41

Annual Meeting Hotel Reservation Form 44

MEDIC 52

Semiannual Meeting News 54

Symposium News 56

Maryland Association of Medical Assistants 89

Information for Authors 104

Classified Advertising 113

Advertising Index 114


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UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Renal Disease, Diagnosis and Management: University of Maryland School of Medicine, Baltimore, Md. Contact: The Committee on Continuing Medical Education, 522 West Lombard St., Baltimore, Md. 21201.

NOVEMBER 19-20, 1970
UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

Seminar in Obstetrics and Gynecology: College of Medicine, University of Florida, Gainesville, Fla. Contact: Division of Postgraduate Education, J. Hillis Miller Health Center, Box 758, College of Medicine, Gainesville, Fla. 32601.

NOVEMBER 20-22, 1970
AMERICAN COLLEGE OF PHYSICIANS

Four-State Regional Meeting—Delaware, District of Columbia, Maryland, and Virginia: Williamsburg, Virginia. Contact: Harry F. Klinefelter, MD, 550 North Broadway, Baltimore, Maryland 21205.

NOVEMBER 21, 1970
SOUTH BALTIMORE GENERAL HOSPITAL

Emergency Medicine Lecture—Acute Injuries to the Hand—Examination and Primary Treatment: 9:30 AM, Assembly Room, South Baltimore General Hospital, 3001 South Hanover St., Baltimore, Md. Speaker: Chris P. Tountas, MD. Contact: South Baltimore General Hospital, 3001 South Hanover St., Balto., Md.

NOVEMBER 24, 1970
JOINT ANESTHESIA STUDY COMMITTEE/BALTIMORE CITY MEDICAL SOCIETY/BALTIMORE CITY HEALTH DEPARTMENT

Meeting: 7:30 PM, Osler Hall, 1211 Cathedral St., Baltimore, Md. Contact: Calbert T. Seebert, MD, Anesthesia Dept., University of Maryland Hospital, Baltimore, Md. 21201.

NOVEMBER 27-28, 1970
DEPARTMENT OF OTOLARYNGOLOGY, UNIVERSITY OF ILLINOIS

Course—Conference on Radiology in Otolaryngology and Ophthalmology: University of Illinois Hospital, Chicago, Illinois. For additional information, write: Professor Valvassori, Radiology Department, College of Medicine, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Illinois 60680.

NOVEMBER 28, 1970
SOUTH BALTIMORE GENERAL HOSPITAL

Emergency Medicine Lecture—General Problems of Emergency Situations (Dermatology): 9:30 AM, Assembly Room, South Baltimore General Hospital, 3001 South Hanover St., Baltimore, Md. Speakers will include members of the hospital's Department of Medicine. Contact: South Baltimore General Hospital, 3001 South Hanover St., Balto., Md.

NOVEMBER 29, 1970
AMERICAN MEDICAL ASSOCIATION

12th National Conference on the Medical Aspects of Sports: Boston, Massachusetts. Contact: American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

NOVEMBER 29-DECEMBER 2, 1970
AMERICAN MEDICAL ASSOCIATION

24th Clinical Convention: Boston, Massachusetts. Contact: AMA Council on Medical Service, 535 North Dearborn Street, Chicago, Illinois 60601.

NOVEMBER 29-DECEMBER 2, 1970
ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES/PUBLIC HEALTH SERVICE/VETERANS ADMINISTRATION

77th Annual Meeting: Washington Hilton Hotel, Washington, D.C. Among the panelists are: Thomas R. Hendrix, MD, professor of medicine, The Johns Hopkins Hospital; and Albert I. Mendeloff, MD, professor of medicine, The Johns Hopkins Medical Center. Contact: Donald L. Thompson, Association of Military Surgeons of the U.S., 8502 Connecticut Ave., Chevy Chase, Maryland 20015.

DECEMBER 2, 1970-FEBRUARY 24, 1971
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Review in Family Practice: University of Maryland School of Medicine, Baltimore, Maryland. Fee: $50; 22 hours of credit may be earned. Contact: University of Maryland School of Medicine, Committee on Continuing Medical Education, Baltimore, Maryland 21201.

DECEMBER 3, 1970
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Emergency Care of the Critically Ill: University of Maryland School of Medicine, Baltimore, Md. Contact: University of Maryland School of Medicine, 522 West Lombard St., Baltimore, Md. 21201.

DECEMBER 3-4, 1970
SAINT BARNABAS MEDICAL CENTER

Postgraduate Course—Gynecologic Endoscopy: Livingston, New Jersey. Contact: James L. Breen, MD, Director, Department of Obstetrics and Gynecology, Saint Barnabas Medical Center, Livingston, N.J. 07039.

DECEMBER 4, 1970
MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND/MARYLAND HOSPITAL ASSOCIATION/PRINCE GEORGE'S GENERAL HOSPITAL

Symposium—The Psychiatric Unit in a General Hospital: 10 AM to 4 PM, Prince George's General Hospital, Cheverly, Maryland. Contact: Medical and Chirurgical Faculty, 1211 Cathedral St., Baltimore, Md. 21201, or call 301-539-0872.

DECEMBER 5, 1970
SOUTH BALTIMORE GENERAL HOSPITAL

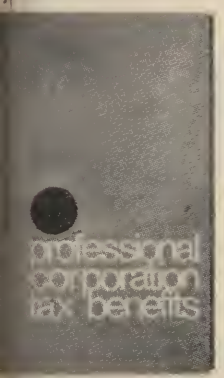
Emergency Medicine Lecture—Care of Injuries—Especially Facial Trauma: 9:30 AM, Assembly Room, South Baltimore General Hospital, 3001 South Hanover St., Baltimore, Md. Speaker: Elliott Berg, MD. Contact: South Baltimore General Hospital, 3001 South Hanover St., Balto., Md.

(Continued on page 14)

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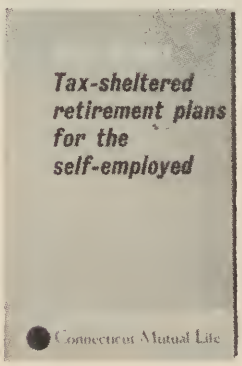


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executive director's newsletter

November, 1970

LEGISLATIVE PROPOSALS

The Council met in special session on Thursday, October 29, 1970, to discuss legislation presently before Congress. Items discussed in the informational session included various proposals for a National Health Insurance System. These proposals include: The Kennedy Proposal, The Griffin Proposal, The Javits Proposal and the AMA's Medicredit Proposal.

LIKELY LAWS

Health Maintenance Organizations and Professional Standards Review Organizations were also discussed at this meeting. These two phrases currently appear in the social security legislation which is now before Congress and which is likely to become law sometime this year.

Health Maintenance Organizations would be given priority with respect to payments under Medicare and Medicaid. Local agencies would be urged to enter into agreements which would provide comprehensive care to patients on the basis of an annual fee. Payments would be based on 95% of the costs of present methods of providing care to such individuals. No HMO would be permitted to have more than 50% of Medicare patients as its participants.

Under the Professional Standards Review Organization setup, the Secretary of HEW would be required to enter into agreements with Medical societies in areas where there are more than 300 physicians. Such societies would be responsible for all peer review activities, and would be required to develop a plan acceptable to HEW in order to become the responsible agency in an area.

If the Secretary did not find such a plan acceptable, or if the local medical society declined to participate, he (the Secretary) would be required to enter into an agreement with any other agency in the area which he deemed suitable.

CLOSED PANEL" MEDICINE

The Council was also informed of various discussions conducted with representatives of the local AFL/CIO. This organization is anxious to promote the "Closed Panel" concept in the practice of medicine.

"CLOSED PANEL" MEDICINE (cont'd)

In a special report, the Council was also advised of present Federal government proposals that would:

Restrict payment for physicians' services under Medicare Part B, on the "basis of a lower percentage of allowable charge" if he (the physician) does not accept assignments under Medicare;

Influence a change in the method of delivering health care by using available funds: first, to pay for health services delivered by prepaid, closed panel programs; second, to pay physicians working under group practice or through cooperative arrangements in a hospital; and lastly, to pay the present fee-for-service arrangement, (providing that funds are left to make such a payment on this basis);

Phase out fee-for-service medicine by establishing local and regional systems, after which a program of National Health Insurance can be implemented. (Presumbly this would be done by placing physicians on a salary basis.)

CHANGES IN MEDICAID PAYMENTS

At a recent meeting with the Governor, initiated by the Secretary of Health and Mental Hygiene, agreement was reached in working towards a goal of payment of Usual, Customary and Reasonable fees for Medicaid services.

The Governor has indicated his desire to increase the services provided medicaid recipients. He is keenly aware of the contributions made by health professionals over the years.

Effective January 1, 1971, payments will be increased to $6.00 for an office visit, $7.00 for a home-day visit; and $8.00 for a home-night visit.

A survey is being made of physicians regarding their current charges to patients for office and home visits so that budgetary figures can be developed for the 1972 fiscal year budget, effective July 1, 1971.

This reflects the continuing high cooperation with the profession by the Secretary's office on health matters.

John Sargeant
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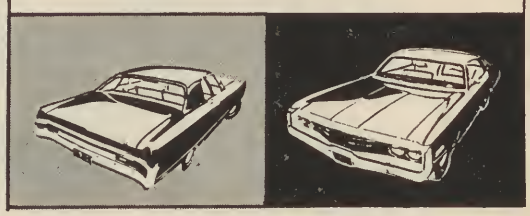
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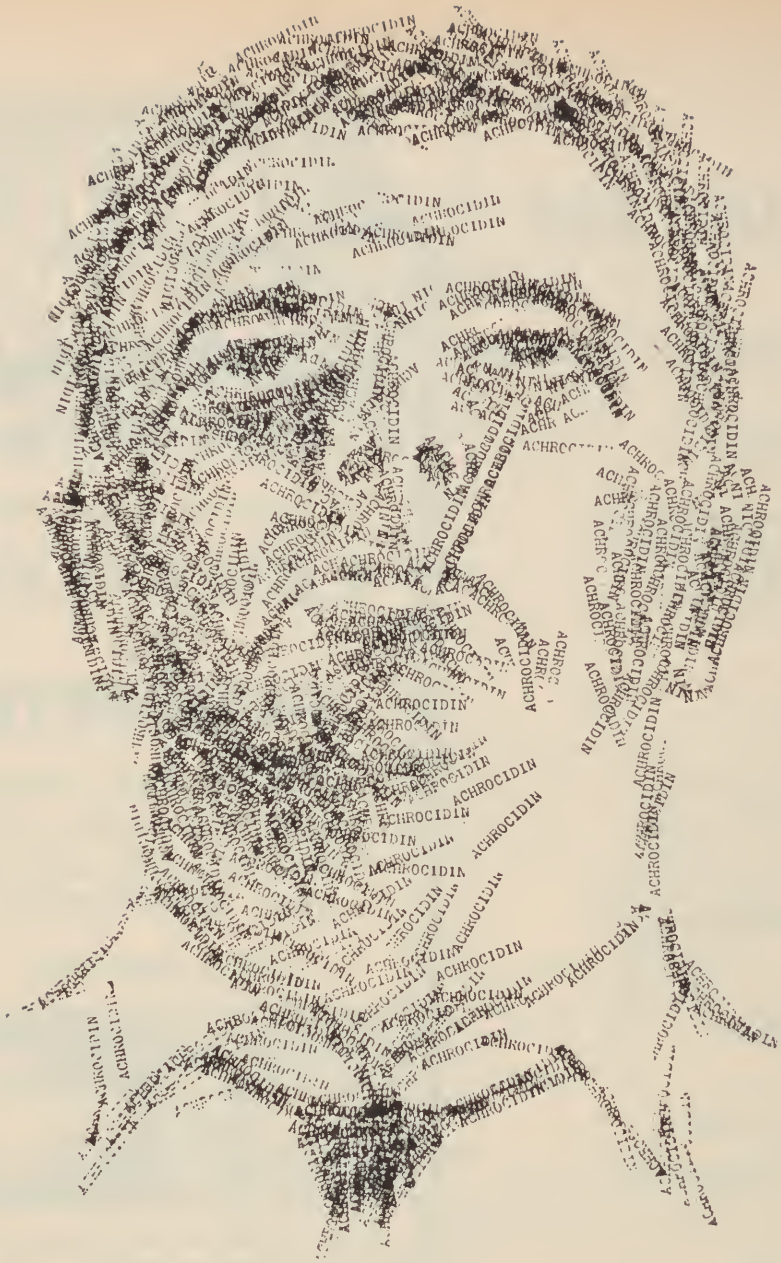
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Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoli dermatitis; photosensitivity; onycholysis, discoloration. *Kidney*—dose-related ris BUN. *Hypersensitivity reactions*—urtic angioneurotic edema, anaphylaxis. *Intracr* —bulging fontanels in young infants. *Te* yellow-brown staining; enamel hypopl *Blood*—anemia, thrombocytopenic purp neutropenia, eosinophilia. *Liver*—cholestas high dosage.

Upon adverse reaction, stop medication treat appropriately.

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FOURTH ANNUAL SEMINAR ON THE MEDICAL ASPECTS OF SPORTS

Saturday, December 5, 1970

Catonsville Community College

800 South Rolling Road, Catonsville

Chairman of Arrangements: Ramsey B. Thomas, MD

9:00 AM Registration—Classroom Building

9:45 AM Opening Remarks

10:00 AM **Stress Limits in the Young Athlete**
Elsworth Buskirk, PhD
Human Performance Research Laboratory
Penn State University
College Park, Pennsylvania

11:30 AM Room A—**Sports and Physical Fitness Programs for Girls of Western Europe Compared With Those in Maryland**
Mrs. Randall C. Coleman
Member, Maryland State Commission on Physical Fitness

Room B—**Field Diagnosis of Athletic Injuries**
Stanford A. Lavine, MD
Orthopaedic Surgeon
Team Physician
University of Maryland
Former Team Physician
Washington CAPS Basketball Team

12:15 PM Lunch—Box lunch will be provided

1:30 PM Room A—**Use and Misuse of Physical Therapy Modalities in the Treatment of Athletic Injuries**
B. Stanley Cohen, MD
Head, Department of Rehabilitation Medicine
Sinai Hospital of Baltimore, Inc.
Baltimore, Maryland

Room B—**Preservation of Sight in Sports**
Joseph W. Berkow, MD
Assistant Chief, Eye Service
Walter Reed General Hospital
Instructor in Ophthalmology
Johns Hopkins University
School of Medicine
Ophthalmologist
Johns Hopkins Hospital
Baltimore, Maryland

2:45 PM **Conditioning of the Athlete (Track and Field)**
Mr. James Kehoe
Director of Athletics
University of Maryland
Former Coach of Track and Field
University of Maryland
College Park, Maryland

Program is sponsored by the Medical and Chirurgical Faculty of the State of Maryland and the Division of Health, Physical Education, and Recreation of Catonsville Community College.

Fourth Annual Seminar on the Medical Aspects of Sports, December 5, 1970

Detach and return this reservation form to:

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1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

Enclosed is my check for $.....

($5 per person; students $2. Includes box lunch.)

Make checks payable to:

Medical and Chirurgical Faculty

Please indicate your preference of the lectures for each of the two hours. First choices will be accommodated as often as space and time permit.

11:30 AM
Sports and Physical Fitness Programs for Girls _____

Field Diagnosis of Athletic Injuries _____

1:30 PM
Use and Misuse of Physical Therapy Modalities _____

Preservation of Sight in Sports _____

Doctors Take Note . . .

(Continued from page 6)

DECEMBER 5, 1970
ST. LUKE'S HOSPITAL MEDICAL CENTER

Chest Disease Symposium: Mountain Shadows Hotel, Scottsdale, Arizona. Contact: Barbara Cahill, public relations director, St. Luke's Hospital Medical Center, 525 North 18th St., Phoenix, Arizona.

DECEMBER 5-10, 1970
AMERICAN ACADEMY OF DERMATOLOGY

29th Annual Meeting: Chicago, Illinois. Contact: Frederick A. J. Kingery, MD, Secretary-Treasurer, American Academy of Dermatology, 2250 Northwest Flanders, Portland, Oregon 97210.

DECEMBER 6-11, 1970
INTERNATIONAL UNION OF AIR POLLUTION PREVENTION ASSOCIATIONS

2nd International Clean Air Congress: Sheraton-Park Hotel, Washington, D.C. The Congress will include a large exhibition of air instrumentation and air pollution abatement equipment; a full schedule of social events for international visitors is planned. Contact: Mr. Arnold Arch, Executive Secretary, Air Pollution Control Association, 4400 Fifth Avenue, Pittsburgh, Pa. 15213.

DECEMBER 9-12, 1970
AMERICAN ACADEMY OF PEDIATRICS/DEPARTMENT OF PEDIATRICS, UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

Postgraduate Course—Congenital and Acquired Heart Diseases in Infants and Children: Happy Dolphin Inn, St. Petersburg Beach, Florida. Inquiries and requests for registration forms should be directed to Gerald Hughes, MD, Secretary for Educational Affairs, American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois 60204.

DECEMBER 12, 1970
HEART ASSOCIATION OF MARYLAND

Day with Doctors: Salisbury, Maryland. Contact: Heart Association of Maryland, 415 N. Charles St., Baltimore, Md. 21201.

JANUARY 2-21, 1971
AMERICAN COLLEGE OF SURGEONS

Scientific Winter Cruise on *S.S. Rotterdam*—Combines shipboard sessions with sectional meeting in Panama City, Caracas, and San Juan. Contact: American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

JANUARY 7-9, 1971
AMERICAN CANCER SOCIETY

National Conference on Cancer of the Colon and Rectum: Hotel del Coronado, San Diego, California. A broad multidisciplinary presentation will be made by leading authorities in epidemiology, etiology, detection, diagnosis, and treatment. Programs and approaches to control this disease will be discussed. Contact: Ronald N. Grant, MD, Vice-President for Professional Education, American Cancer Society, 219 East 42nd St., New York, N.Y. 10017.

JANUARY 13-15, 1971
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Coronary Atherosclerotic Heart Disease: Prevention, Treatment and Rehabilitation: Atlanta, Georgia. Contact: American College of Physicians, 4200 Pine St., Philadelphia, Pa.

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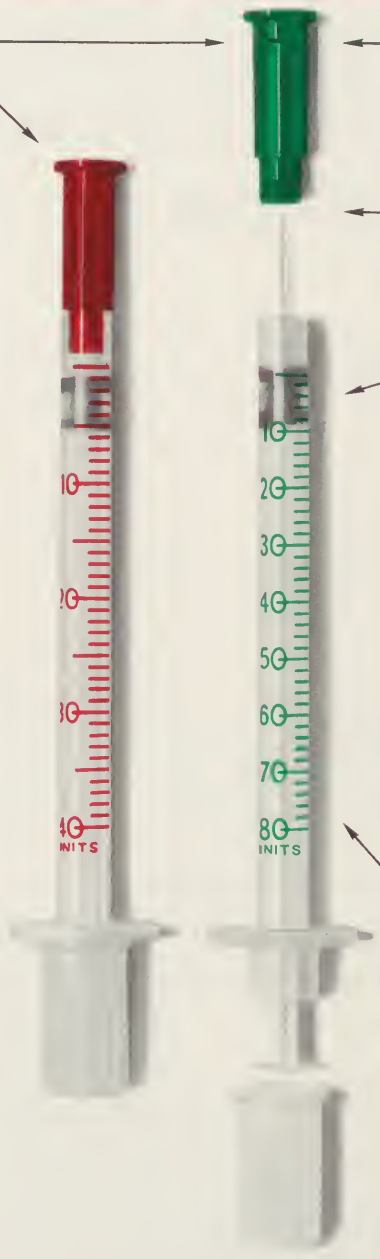
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Frederick County Medical Society

September Meeting News

"How many doctors would be willing and able to give the time?" "What would be the goals and could they be accomplished?" These were two of the questions asked in response to a proposal from the Community Health Services Committee to establish a steering committee composed of physicians from the society and responsible laymen from the community. The committee gave its report at the business-oriented September meeting of the Frederick County Medical Society.

LeRoy Davis, MD, in the absence of the permanent chairman of the committee, presented the report to the society. In the ensuing discussion, it was suggested that a layman-physician committee, as recommended, could substantially improve public relations. Furthermore, the committee could eliminate much duplication of effort in various "medical-community-organizational" concerns.

Basically, such a committee would involve lay members of the community in finding solutions to problems related to medical services. Such matters as the shortage of physicians, it was noted, are usually blamed upon those physicians who in reality are making the greatest efforts to remedy this problem. It was suggested that by involving lay persons with such problems, a better understanding of the medical profession by the community might be created. Because of the many ramifications of such a committee and the many details to be considered, it was decided to mail a detailed report of the Community Health Services Committee to each member to study, and to consider the recommendations at the next meeting.

A report was given by George Smith, MD, Chairman of the Physician Procurement Committee. He urged the members to be constantly on the alert for students or those in training who might be interested in practicing in Frederick County and to keep his committee posted on their names and addresses.

Charles Wright, MD, reported to the society on the meeting of the House of Delegates, and on the Med-Chi meeting in Hershey.

President A. M. Powell, Jr., MD, announced that with the departure of Thurman Mott, MD, from private practice, there was a need for a psychiatrist in the Day Unit Services of the hospital. President Powell also announced a request for a physician to serve on the local CAC board of directors as well as a request by local law enforcement authorities for a physician willing to serve as physician for the county jail. No immediate action was taken on these requests.

In keeping with its desire to actively assist the Red Cross Blood Donor program, the membership voted unanimously to join in the blood donor program as group volunteers in the name of the society.

The membership welcomed three new active members: Timothy Hickey, MD, associated in general practice with J. R. Poirrer, MD, and W. J. Riddick, MD; Philip Shapiro, MD, internist; and Martin Lipson, MD, ophthalmologist. The hope was expressed that they might enjoy many pleasant years in Frederick County.

Ernest A. Dettbarn, MD
Journal Representative

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ART AND HOBBY EXHIBIT

Annual Meeting of the Medical and Chirurgical Faculty

MAY 12, 13, 14, 1971 Baltimore Civic Center

APPLICATION FOR ART AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Art and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height: .....

3. Electrical or other requirements: .....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

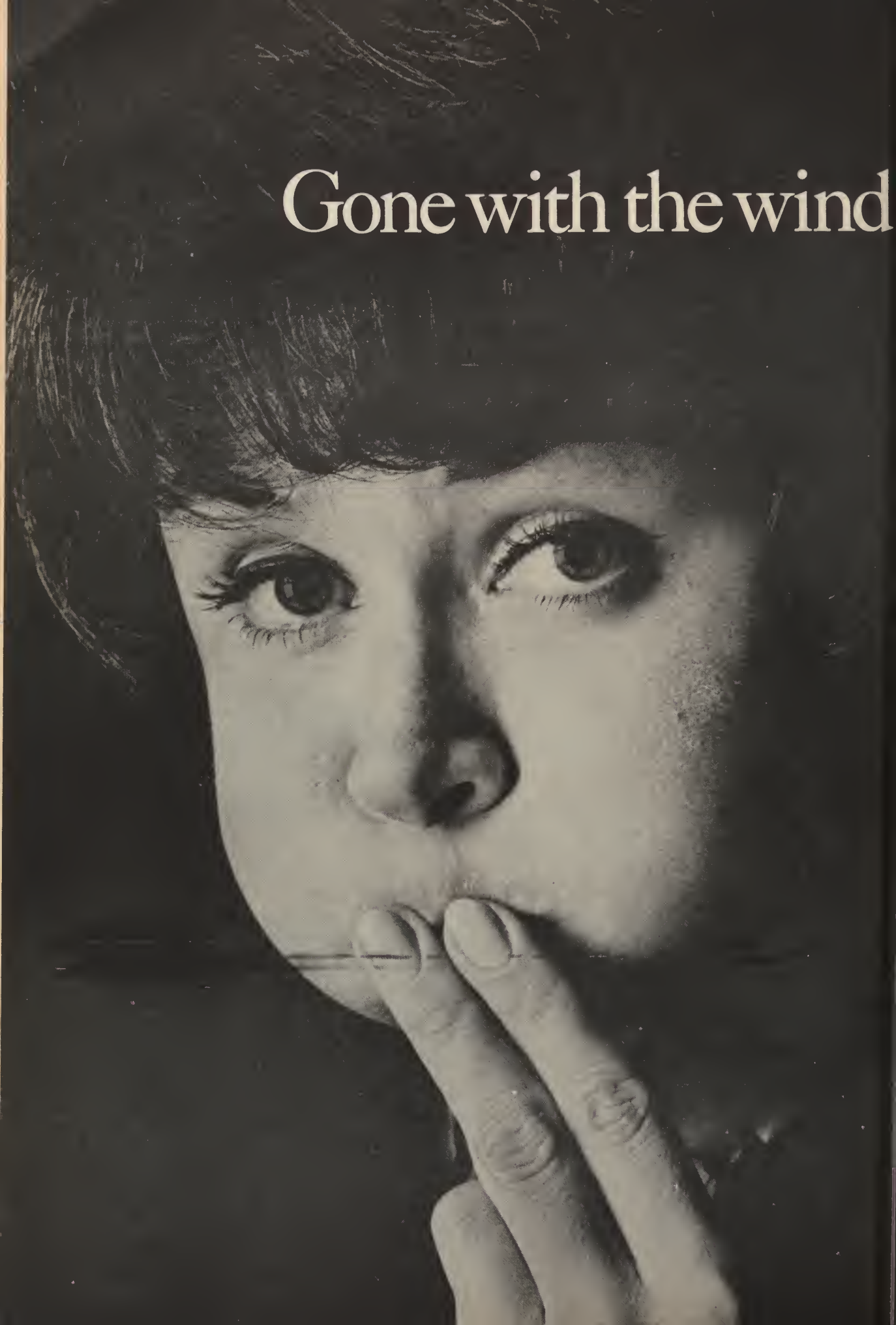
6. Telephone number of exhibitor: .....

An Art and Hobby Exhibit will be held during the 173rd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible and entries will be accepted until all exhibit space is allotted.

Entries should be delivered to the Baltimore Civic Center, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, May 11, 1971. They must be removed on Friday, May 14, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.

A Hobby Corner at the Semiannual Meeting of the Faculty in Hershey created a great deal of interest. LET'S MAKE IT A REAL "SHOW" FOR THE 1971 ANNUAL MEETING. SUBMIT YOUR ENTRIES NOW!




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"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

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SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

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Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

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Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide
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one dose does both: frees captured gas...neutralizes free acid

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Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

2/68—After 11 days of treatment. ythema is seen at site of keratoses. In dition, numerous lesions not apparent ior to therapy have become manifest sharply defined reactions. Intervening in, also treated, shows no response to erapy.

19/69—One year after cessation of erapy. Skin appears clear with no evi- nce of scarring. Examination reveals k of recurrence or the formation of w lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning the site of application. Other local reactions included dermatiti scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scalin swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice da with a nonmetal applicator or suitable glove in an amount of t solution or cream sufficient to cover the lesion. When Efudex i applied to a lesion, a response occurs with the following seque erythema, usually followed by vesiculation, erosion, ulceration necrosis and epithelization. The lower frequency and intensity activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammator reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of t lesion may not be evident for 1 to 2 months following cessation Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—contai 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (meth and propyl).

Clinical Studies: The effectiveness of the three preparations a determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions wh complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or m was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 1 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxi potential of fluorouracil, some physicians preferred to use the 2 solution when large areas were to be treated. Approximately 3(of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Meetings, Activities and Acquisitions

Following my visit to Western Maryland hospital libraries, I visited hospital libraries in Anne Arundel General Hospital, Annapolis; Calvert County Hospital, Prince Frederick; and St. Mary's Hospital, Leonardtown. In Annapolis, Dorothy Mumford was in the process of moving their library sans shelves and other equipment. An integrated medical staff-nursing library collection will be set up in a section of the original building.

At Calvert County Hospital, and also at St. Mary's, the acting librarians, Mrs. Rosemary Poling and Mrs. Katherine Thompson, respectively, both in Medical Records, discussed ways in which the Med-Chi Library can assist them in meeting the needs of their staffs.

* * *

In cooperation with Paul Huffington, MD, of Salisbury, and the Regional Medical Program for Maryland, plans are being made for a series of video tapes illustrating effective use of the existing medical libraries. These tapes will be available to component societies and other interested groups.

* * *

One of the outstanding acquisitions of the past month is *Operative Surgery,* edited by Charles Rob and Rodney Smith, and originally published from 1968 to 1970 by Butterworth, and distributed by J. B. Lippincott in the U.S. Eleven volumes have been published to date, with three more forthcoming.

The library has acquired the following volumes: 1) *General Principles and Breast;* 2) *Thorax;* 3) *Vascular Surgery;* 4-5) *Abdomen and Rectum and Anus;* 6) *Head and Neck and Lymph Nodes;* 7) *Plastic Surgery;* 8-9) *Orthopaedics;* 10) *Eyes and Ear, Nose and Throat;* and 11) *Hand.*

The three other volumes will be: *Genito-urinary System; Gynaecology and Obstetrics;* and *Neurosurgery.*

These texts are well illustrated and each volume is indexed separately. They constitute a major addition to the surgery collection. The individual volumes are authored by renowned specialists in the subject field. Volumes may circulate individually.

* * *

On November 19, 1970, the Baltimore Hospital Librarians' Association will meet at Williams and Wilkins in Baltimore at 1 PM.

On November 19, 1970, the Baltimore Chapter of the Special Libraries will meet at Evergreen House. At this dinner meeting, Miss Elizabeth Baer will speak on the "History of Evergreen House" and Miss Dorothy Miner will discuss "Care of Manuscripts".

On December 8, 1970, the Tri-State Hospital Association will conduct a meeting in Washington, D.C., sponsored by the Baltimore Librarians' Association. For information, contact: Mrs. Lorene Pita, Librarian, Provident Hospital, 1514 Division St., Baltimore, Md., or call 523-4005 (Balto.).

NEW ACCESSIONS—BOOKS
(Arranged by author and title)

Abrams, M. E.
Medical computing. New York, American Elsevier, 1970.

Advances in surgery, v. 3. Chicago, Year Book Medical Publishers, 1968.

American College of Allergists.
Membership directory, 1970. Boulder, Colo., 1970.

The Artificial cardiac pacemaker; history, development and clinical application. By H. J. Th. Thalen, J. W. van den Berg, J. N. Homan van der Heide, and J. Nieveen. Assen, Van Gorcum; Springfield, Ill., Thomas, 1969.

Association of American Medical Colleges.
Admission requirements of American medical colleges, including Canada, 1970. Evanstown, Ill.

Bargen, Jacob Arnold.
Chronic ulcerative colitis; a lifelong study. Springfield, Ill., Thomas, 1969.

Barnard, Christiaan Neethling.
One life. By Christiaan Barnard and Curtis Bill Pepper. New York, Macmillan, 1970.

Biomechanics; technique of drawings of movement and movement analysis. Proceedings of the First International Seminar on Biomechanics, Zurich, Aug. 21-23, 1967. Edited by J. Wartenweiler, E. Jokl, and M. Hebbelinck. Baltimore, University Park Press, 1968. (Medicine and sport, v.2).

Bosch, Gerhard.
Infantile autism; a clinical and phenomenological-anthropological investigation, taking language as the guide. New York, Springer-Verlag, 1970.

Cell kinetics in human leukemia. Baltimore, Williams & Wilkins, 1968.

Chemotherapy of cancer. Edited by Warren H. Cole. Philadelphia, Lea & Febiger, 1970.

Criep, Leo H.
Clinical immunology and allergy. 2nd ed. New York, Grune & Stratton, 1969.

Crohn, Burrill Bernard.
Understand your ulcer; a manual for the ulcer patient. rev. ed. New York, Funk and Wagnalls, 1968.

Davis, Hallowell.
Hearing and deafness. By Hallowell Davis and S. Richard Silverman. 3d ed. New York, Rinehart and Winston, 1970.

Dekaban, Anatole S.
Neurology of early childhood. Baltimore, Williams & Wilkins, 1970.

Dertinger, Hermann.
Molecular radiation biology; the action of ionizing radiation on elementary biological objects. By H. Dertinger and H. Jung. New York, Springer-Verlag, 1970. (Heidelberg Science Library, v.12).

Edwards, Sam A.
Health care system variables, an annotated bibliography, 1969. By Sam A. Edwards and O. Ray Hurst. San Antonio, Health Resources Planning Unit, Texas Hospital Association, 1969.

Elia, Joseph Charles.
The dizzy patient. Springfield, Ill., Thomas, 1968.

Fitch, Grace E.
The role and responsibilities of the practical nurse. New York, Macmillan, 1969.

Fox, John P.
Epidemiology; man and disease. By John P. Fox, Carrie E. Hall, and Lila R. Elveback. New York, Macmillan, 1970.

Fulford, George Edwin.
Amputation and prostheses; a survey in northwest Europe and North America; report on the first British Limbless Ex-Service Men's Association travelling scholarship, by G. E. Fulford and M. J. Hall. Bristol, published under the sponsorship of the British Limbless Ex-Service Men's Association by J. Wright, 1968.

Gt. Brit. Advisory Panel on Research Establishments.
Code of practice for the protection of persons exposed to ionising radiations in research and teaching. 2nd ed. London, HMSO, 1968.

Gt. Brit. Dept. of Health and Social Security.
Amphetamines, barbiturates, LSD and cannabis; their use and misuse. London, HMSO, 1970.

Hague, James E.
The American hospital system; papers presented at the dedication program of the Baptist Memorial Hospital Union—East Unit, Memphis, Tenn., Feb. 19, 1968. Pensacola, Fla., Hospital Research & Development Institute, 1968.

Harvey, Abner McGehee.
Differential diagnosis; the interpretation of clinical evidence. By A. McGehee Harvey and James Bordley, III. 2nd ed. Philadelphia, Saunders, 1970.

Hooper, Reginald.
Patterns of acute head injury. Baltimore, Williams & Wilkins, 1969.

Huisking, Charles L.
Herbs to hormones: the evolution of drugs and chemicals that revolutionized medicine; the memoirs of Charles L. Huisking. Essex, Conn., Pequot Press, 1968.

International Symposium on Exercise Biochemistry. 1st, Brussels, 1968.
Biochemistry and exercise; proceedings. Edited by J. R. Poortmans. Baltimore, University Park Press, 1968. (Medicine and sport, v.3)

Jeor, Sachiko T. de St.
Low protein diets for the treatment of chronic renal failure. Salt Lake City, University of Utah Press, 1970.

Joint Commission on Mental Health of Children.
Crisis in child mental health; challenge for the 1970's; report. New York, Harper & Row, 1970.

Jokl, Ernst.
Exercise and altitude. Edited by Ernst Jokl and Peter Jokl. Basel, Karger, 1968. (Medicine and sport, v.1).

Jones, Arthur Morgan.
Modern trends in cardiology, 2. New York, Appleton-Century-Crofts, 1969.

Kindregan, Charles P.
Abortion, the law, and defective children; a legal-medical study. Washington, Corpus Books, 1969.

Kreyberg, Leiv.
Aetiology of lung cancer; a morphological, epidemiological, and experimental analysis. Oslo, Universitetsforlaget, 1969.

Kugelmaas, I. Newton.
The autistic child. Springfield, Ill., Thomas, 1970.

Lenneberg, Edith.
The ileostomy patient, a descriptive study of 1,425 persons. By Edith Lenneberg and John L. Rowbotham. Springfield, Ill., Thomas, 1970.

McMurtry, James G.
Neurological surgery; 2,000 multiple choice questions and answers referenced to textbooks and journals. Flushing, N.Y., Medical Examination Pub. Co., 1970. (Medical examination review book, v.19).

Maroon, Joseph C.
What you can do about cancer. Garden City, N.Y., Doubleday, 1969.

Medical and Chirurgical Faculty of the State of Maryland.
Laws, rules and regulations with which physicians must comply. Baltimore, 1970.

National Institute on Amphetamine Abuse, 1st, Edwardsville, Ill., 1966.
Amphetamine abuse. Edited by J. Robert Russo. Springfield, Ill., Thomas, 1968.

Nutrition in renal disease; proceedings of a conference, held at the University of Manchester on June 29 & 30, 1967. Edited by G. M. Berlyne. Baltimore, Williams and Wilkins Co., 1968.

Operative surgery, v. 1-14. 2nd ed. Edited by Charles Rob and Rodney Smith. Philadelphia, Lippincott, 1968-70.

The Production and hazards of a hyperbaric oxygen environment; proceedings of a symposium held at University College, London, Jan. 1968. Edited by G. S. Innes. Oxford, Pergamon Press, 1970.

Recent advances in neurology. Edited by Fred Plum. Philadelphia, Davis, 1969. (Contemporary neurology series, 6).

Renal disease and hypertension; proceedings of the 8th annual conference of the U.S. Public Health Service cooperative study, 1969. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, Federal Health Programs Service, 1969.

Riklan, Manuel.
Subcortical correlates of human behavior; a psychological study of thalamic and basal ganglia surgery. By Manuel Riklan and Eric Levita. Baltimore, Williams & Wilkins, 1969.

Ruesch, Jurgen.
Communication; the social matrix of psychiatry, by Jurgen Ruesch and Gregory Bateson. New York, Norton, 1968.

Sagall, Elliot L.
The law and clinical medicine, by Elliot L. Sagall and Barry C. Reed. Philadelphia, Lippincott, 1970.

Shryock, Richard Harrison.
Medicine in America; historical essays. Baltimore, Johns Hopkins Press, 1966.

Spiro, Howard M.
Clinical gastroenterology. New York, Macmillan, 1970.

Symposium on Homeostatic Regulators, London, 1969.
Homeostatic regulators; a Ciba Foundation symposium held jointly with the Wellcome Trust. Edited by G. E. W. Wolstenholme and Julie Knight. London, Churchill, 1969.

Symposium on Mutation as Cellular Process, London, 1969.
Mutation as cellular process; a Ciba Foundation symposium. Edited by G. E. W. Wolstenholme and Maeve O'Conner. London, Churchill, 1969.

Tudhope, G. R.
The thyroid and the blood. London, Heinemann, 1969.

U.S. National Institutes of Health.
The clinical center; current clinical studies and patient referral procedures. Revised ed. Bethesda, U.S. Dept. of Health, Education, and Welfare, National Institutes of Health, 1970.

U.S. National Institutes of Health. Bureau of Health Professions Education and Manpower Training.
Selected training programs for physician support personnel. Bethesda, 1970.

Welsh, Robert C.
The new report on cataract surgery; proceedings of the first biennial Cataract Surgical Congress, Miami Beach, Fla. Compiled and edited by Robert C. Welsh and Judith Welsh. Miami, Miami Educational Press, 1969.

Wilder-Smith, A. E.
The drug users, the psychopharmacology of turning on. Wheaton, Ill., H. Shaw, 1969.

The Year book of orthopedics and traumatic surgery. 1969. Chicago, Year Book Medical Publishers. (Practical medicine year books).

Ziai, Mohsen.
Pediatrics. Edited by Mohsen Ziai, with Charles A. Janeway and Robert E. Cooke. Boston, Little, Brown, 1969.

BIBLIOGRAPHIES ON DRUG ADDICTION IN MED-CHI LIBRARY

1. **Bibliography on drug addiction,** April 19, 1967. Prepared by Med-Chi Library staff.
2. **Bibliography on drug addiction,** February, 1968. Prepared by Med-Chi Library staff.
3. **Drug abuse and crime,** Jan. 1967-Dec. 1969. Prepared by the National Library of Medicine. (Literature search no. 70-5)
4. **Mortality or self-destructive behavior** in drug abuse, Jan. 1967-Dec. 1969. Prepared by the National Library of Medicine. (Literature search no. 70-3)
5. **Psychotherapy in drug addiction or abuse,** Jan. 1964-Aug. 1968. Prepared by the National Library of Medicine. (Literature search no. 2-69)

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RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

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2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

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5. Has exhibit been shown at other medical meetings? _____

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THE MONTH IN WASHINGTON

The American Medical Association has emphasized that the quality of medical care should not be sacrificed for the sake of economy in government health care programs.

William O. LaMotte Jr., MD, of Wilmington, Del., chairman of the AMA's Council on Legislation, repeatedly stressed the importance of assuring high quality care in testimony at a Senate Finance Committee hearing on proposed changes in medicare and medicaid.

He also pointed out the advantages of the AMA's plan for review of physicians' services aimed at holding down costs over an alternative proposal before the committee. The AMA supported a provision of the proposed legislation that would provide for physical therapy services but opposed including chiropractic services under medicare.

Dr. LaMotte said that there should be pilot projects before a "Health Maintenance Organization" program is started nationwide. A HMO would provide both hospitalization and physicians' services for medicare patients for a set per capita amount.

"There are questions regarding in-fact cost savings, as well as the quality of health care which may be provided when there are economic incentives to providers to reduce utilization," the AMA spokesman said. "We wish to assure that medicare patients uniformly receive the best quality care.

"To this point of quality care, we have one additional concern. As defined in the bill, the HMO may be a 'for-profit' organization and one managed, controlled, and operated by lay individuals. Under such circumstances, the incentive for profit or lack of the basic essentials of knowledge, training, and experience in medical matters, or both, could result in the patient being furnished less than the optimum of quality care. To avoid such a result, we recommend that organizations delivering health care should be under the control and guidance of medical personnel."

Dr. LaMotte also questioned the desirability of a provision that would restrict payments to institutions.

"Will this section create different classes of services based upon the ability or desire of patients to pay for additional services?" Dr. LaMotte asked. "A goal of medicare was to make available to all persons over 65 the same level of health care available to other individuals. Has that goal now been changed?"

He assured the committee that the nation's physicians as a group "share the concern of the public and the Congress" concerning rising health care costs. But, he said, the AMA must oppose a provision that would substitute an arbitrary statutory limitation on physicians' fees for the "reasonable" fee now allowed. He said cost factors were too complex for such a simple solution and that the arbitrary limitation would make the medical profession the only sector of the nation's economy under price or wage controls.

As for utilization or peer review, Dr. LaMotte said the AMA objects "most forcefully" to a provision of the pending legislation that would have nonmedical groups act as review teams and pass judgment on medical services.

Following Dr. LaMotte's testimony, the committee modified somewhat the professional review amendment sponsored by Sen. Wallace F. Bennett of Utah, second-ranking Republican on the committee, after he earlier heard an AMA spokesman advocate the peer review principle.

The modified version relaxed a requirement for preadmission clearance to hospitals for elective surgery to leave the matter of such a requirement up to review agencies. But the committee version would permit the Secretary of Health, Education, and Welfare to enter into agreements with organizations or agencies other than state medical societies for administering the review programs in areas with 300 or more physicians. The AMA strongly contended that the responsible agencies should be only state medical societies.

Meade Whitaker, tax legislative counsel for the Treasury Department, asked the committee to add a provision to the legislation that would require health insurance companies and carriers to report unassigned payments to physicians and other providers of health care. Unassigned payments go directly to patients to be given by them to their physicians. A sim-

ilar proposal was knocked out of last year's tax reform legislation by a House-Senate conference committee.

The AMA—along with the carriers and HEW—have opposed mandatory reporting by carriers of unassigned payments on the grounds that it would be difficult and costly to furnish the data and that, in many instances, the patient might not have passed along the payment to the physician. This last circumstance would put on the physician the unfair burden of proving that he did not receive such income.

Whitaker said that the Internal Revenue Service had found that more than half of 3,000 physicians who received $25,000 or more in government medicare or medicaid payments in 1968 failed to report a substantial amount of their income to the tax agency.

The audits were ordered after the Senate committee raised the question of whether physicians receiving a large total of annual payments under the government medical programs were paying income taxes on all of it.

"Preliminary results indicate a number of instances of substantial unreported income, including some where the omission exceeds $100,000," Whitaker said.

The committee had turned over to the IRS the names of 11,000 physicians who had received medicare or medicaid payments exceeding $25,000 in 1968. Whitaker said that 4,000 of the 11,000 physicians "justified detailed audit" and 3,000 of the audits were nearly complete, and that "about half of the 3,000 we audited will come up with substantial deficiencies" in reported income.

Sen. Russell B. Long (D., La.) said that the investigation had disclosed a "vast area of tax cheating" and urged the IRS to initiate criminal prosecutions against physicians who had hidden their medicare or medicaid income.

Long added that as far as he could see, the AMA, "from the ethical point of view on taxes, has been completely forthright and honorable and sought to shield no one."

Long agreed with the AMA *not* to include chiropractic services in the medicare program. He told a chiropractic spokesman testifying before the committee:

"Insofar as you can convince me that you are doing somebody some good, I would be willing to cooperate, but I am not inclined to cooperate when I am not convinced that you have. My feeling is the only time a chiropractor tried it on me it didn't do any good, so I guess I am prejudiced by that."

* * *

The Nixon Administration came out strongly against the cradle-to-grave comprehensive national health insurance legislation sponsored by Sen. Edward M. Kennedy (D., Mass.) and supported by organized labor leaders.

John G. Veneman, Under Secretary of Health, Education, and Welfare, testified before the Senate Committee on Labor and Public Welfare that the program that would be provided by the legislation "is not a proper or workable approach to the solution of the health problems of this nation" and would cost $77 billion in the first year of full operation.

The committee held hearings on the legislation this year only to publicize it and to provide a forum for its supporters to expound their views. The sponsors resorted to a gimmick—a change in the financing provision—to get it before the labor and public welfare panel after it first was sent to the finance committee which ordinarily handles such legislation. The same maneuver was used in 1949 to get a hearing on President Truman's national health insurance proposal. Kennedy and six co-sponsors of his legislation are members of the labor and public welfare committee.

"There are those who insist that the present system is sound and should be left alone," Veneman said. "Others demand that we throw out the baby with the bath water and replace our pluralistic health enterprise with some monolithic scheme in which the federal government controls everything.

"I think both points of view are wrong. The deep troubles of the health care enterprise have been nurtured by many factors, not the least of which is past failure to plan and prepare for the soaring demand that observant people knew was coming. But I do not believe that past neglect means that we now have to start over and pursue some course of action that would be entirely alien to our basic traditions.

"The central issue, over and above the inconceivable commitment of general fund revenues for S. 4323, is whether such a drastic abandonment of existing mechanisms in our health care system is necessary to remedy the defects in the system and whether, in fact, it may not create more problems than it will solve . . .

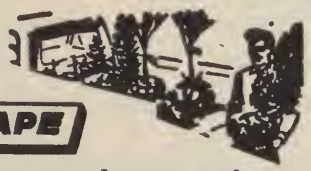
"Government is currently purchasing more than 36% of the total output of the health care system. This figure indicates that the use of its purchasing power is probably the government's primary source of leverage to initiate changes in the organization and delivery of health care. As government becomes more involved in financing, it also has a greater responsibility to remedy the defects in the system.

"The question now is whether we should divert revenues need-

ed for income maintenance, nutrition, the environment, housing, and other health-related efforts, and concentrate them all on creating the federal system of health financing proposed by S. 4323. To do so would assume the failure of the measures currently proposed to correct defects in the present mixed public-private health system.

"In short, we (the administration) have made substantive recommendations for improving the organization and delivery of services, increasing the efficiency of the health care industry, and for stimulating necessary reorganization and redistribution, through financing mechanisms. We are very much aware of the urgent need for solution of many problems in the financing and delivery of care, and have committed ourselves to an insurance program to provide protection to low income families with children.

"However, we have serious reservations about the desirability of embarking on a program like S. 4323, that will protect not only the unprotected but those with substantial coverage, and that will radically restructure the health financing and health service industry without having tested the instruments of change."



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MEDICAL NEWS

Russell A. Nelson, MD, and **Talmadge T. Pinkney, MD,** both of Baltimore, **Stephen K. Padussis, MD,** of Lutherville, and **Austin B. Rohrbaugh, MD,** of Chevy Chase, were all reappointed to three-year-terms on the Comprehensive Health Planning Council of Maryland.

Herbert Marschark will succeed William Hanson Moore for a five-year-term on the Advisory Council on Hospital Licensing.

Governor Marvin Mandel made the appointments.

* * *

Richard E. Hoover, MD, chief of ophthalmology at the Greater Baltimore Medical Center, has been named one of the two winners of the 1970 Migel Medal presented annually by the American Foundation for the Blind for outstanding service in the field of blindness.

Dr. Hoover, who created the long-cane travel technique used widely by blind persons, received his MD degree from The Johns Hopkins University School of Medicine. He took his internship and residency in ophthalmology at the Wilmer Institute of The Johns Hopkins Hospital.

* * *

The following Maryland physicians were recently certified as Diplomates of the American Board of Anesthesiology: **Michael Ashman, MD,** Baltimore; **Maria Pia Caldini, MD,** Baltimore; **Donald M. Eiler, MD,** Bethesda; **Fred C. Hausler, Jr., MD,** Ellicott City; **Robert A. Hoffenberg, MD,** Baltimore; **Shakuntla Devi Mahajan, MD,** Hyattsville; **Woo Young Park, MD,** Rockville; **John C. Payne, MD,** Seat Pleasant; **Raymond B. Schwartz, MD,** Andrews AFB; **Kate Sewall, MD,** Baltimore; and **Joseph R. Wilson, MD,** Rockville.

* * *

Bertram S. Brown, MD, director of the National Institute of Mental Health, was the keynote speaker at a conference on consumer health held recently in Chevy Chase.

Eugene H. Guthrie, MD, MPH, executive director of the Maryland Comprehensive Health Planning Agency, spoke on "Challenges to Leadership".

Other featured speakers included: **Daniel Thursz, DSW,** dean of the School of Social Work at the University of Maryland; **Theodore O. Cron,** president of the American Patients Association; **Edward Davens, MD,** coordinator of Maryland's Regional Medical Program; **W. Lewis Holder, MD,** associate health officer in the Montgomery County Health Department; and **Harry F. Walker,** executive director of the Maryland State Commission on Aging.

* * *

Donald Procter, MD, Patricia Murtagh, MD, and **Edward P. Radford, MD,** all of The Johns Hopkins University, recently participated in the Air Pollution Medical Research Conference held in New Orleans.

Dr. Procter and Dr. Murtagh prepared and presented "The Study of Bronchial Caliber in Excised Dog Lobes" during the session on fundamental mechanisms. Dr. Radford presented "Air Pollution Problems Associated with Nuclear Power Generation" during the session on chronic fibrosing diseases.

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Assuming the office of Third Vice-President of the Medical and Chirurgical Faculty, after the Annual Meeting in 1970, is Daniel Irvin Welliver, MD, of Westminster.

Dr. Welliver received an AB degree from Western Maryland College in 1950 and his MD from the University of Maryland in 1954. He completed his internship at the University of Michigan Hospital in 1955. As a general practitioner in Westminster, Dr. Welliver holds membership in various medical societies, and presently is Director and Vice-President of the Maryland Academy of General Practice.



Dr. Welliver

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In correction of a news item that appeared on page 41 of the September Journal, **Paul M. Leand, MD,** of Baltimore, formerly on the full-time staff of The Johns Hopkins University School of Medicine, has entered the private practice of surgery. He is still a member of the surgical staff of The Johns Hopkins Hospital, where he will continue to practice surgery and teach in the residency and surgical medical student programs.

Dr. Leand is board certified

in general surgery and thoracic surgery. His office is located at 222 West Cold Spring Lane in Baltimore.

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The Senate recently approved, by a vote of 64 to 1, a bill allowing family medicine grants. This bill will amend the Public Health Service Act to provide grants to medical schools and hospitals and will assist them in establishing programs of training in the field of family practice.

* * *

J. Emmett Queen, MD, has been appointed director of medical affairs at the Maryland Blue Cross.

In his new position, Dr. Queen will serve Blue Cross as "the prime resource on all medical matters". He will be active in the development of broad medical policy and in the structuring of new forms of coverage programs. He will also provide liaison with the medical profession and coordinate all Blue Cross activities in the area of claims and utilization review.

Formerly, Dr. Queen had served as director of medical education at Bon Secours Hospital.

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Robert H. Haslam, MD, director of the John F. Kennedy Institute at The Johns Hopkins University, recently participated in a mental health conference held in Birmingham, Alabama.

Sponsored by the Center for Development and Learning Disorders at the University of Alabama, the meeting brought together administrators of all university-affiliated facilities for training professional workers in such areas as rehabilitation, medicine, social work, speech pathology, and psychology.

* * *

Norman G. Parsons, Chevy Chase, was recently appointed deputy director of the Social Security Administration's Bureau of Health Insurance, the bureau that administers the nation's Medicare program, according to Robert M. Ball, Commissioner of Social Security.

* * *

James R. Nickel, MD, resident in pathology at The Johns Hopkins Hospital and **George W. Wharton, MD,** resident in orthopedic surgery at the University of Maryland Hospital, were recently awarded grants by the Southern Medical Association Residency Training Loan Fund.

These grants allow the recipients to complete a chosen number of years of training without adding to their indebtedness while still receiving an income.

* * *

Hugh Davis, MD, of The Johns Hopkins University School of Medicine, and **Ruth Finkelstein, MD,** of Sinai Hospital, recently participated in a convention held at the University of Alabama, by the School of Medicine's Division of Continuing Medical Education and the Department of Obstetrics and Gynecology there.

Dr. Davis spoke on "Observation on the Mechanisms of Action of the IUCD" while Dr. Finkelstein's topic was "Prevention of Conception in the Adolescent Patient".

* * *

Victor Almon McKusick, MD, was recently appointed to serve on the National Advisory Research Resources Council, according to the Secretary of Health, Education, and Welfare.

* * *

The appointment of **Claudewell S. Thomas, MD,** as director of the division of Mental Health Service Programs in HEW's National Institute of Mental Health, Health Services and Mental Administration, Chevy Chase, was announced recently by Bertram S. Brown, MD, NIHM director.

Dr. Thomas will have the responsibility of administering NIHM programs which support nationwide mental health services. These services include both the construction and staffing of community mental health centers and the improvement of state and local mental health services. Dr. Thomas will also seek grants for the improvement of state mental hospitals, as well as promote mental health insurance and develop occupational mental health programs.

* * *

Announcement of the **1971 Alfred A. Richman Essay Contest** was made recently by the American College of Chest Physicians. The annual contest offers undergraduate medical students throughout the world the opportunity to submit, in open competition, manuscripts on any phase of the diagnosis and treatment of cardiovascular or pulmonary diseases.

Research or review articles relating to the diagnosis or treatment of cardiovascular or pulmonary diseases are acceptable. In accord with the rules of the contest, preceptors are at liberty to assist the student in selecting a suitable subject and guide him in the preparation of his essay.

Three cash prizes totaling $1,000 are awarded annually. The first prize will be $500; the second will be $300; and the third will be $200. Each winner will also receive a certificate of merit. A trophy inscribed with the name of the winner and the name of his school will be presented to the winner's school.

The winning essayist will be announced by the judges in June 1971.

An official application form may be secured by writing: Essay Contest, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

* * *

The Maryland chapter of the

American College of Surgeons recently elected its officers. They are: President, **John O. Sharrett, MD,** Baltimore; Vice-President and President-Elect, **J. Parran Jarboe, MD,** La Plata; Secretary, **William J. McClafferty, MD,** Baltimore, and Treasurer, **Sullins G. Sullivan, MD,** Baltimore.

* * *

Baltimore County General Hospital has acquired an **operational heliport** to receive accident cases for emergency treatment. The state police helicopter which uses it has already been credited with saving many lives.

* * *

The National Heart and Lung Institute in Bethesda is conducting a one-year survey in the town of Framingham, Massachusetts, to determine the frequency of heart attacks and strokes in a general population.

Called the **Framingham Cardiovascular Disease Survey,** the new study will collect data on all acute heart attacks, strokes, and other serious clinical manifestations of cardiovascular diseases occurring among Framingham inhabitants between June 15, 1970 and July 1, 1971.

The survey will be directed by Manning Feinleib, MD, Chief of the Field Epidemiology Research Section at the National Heart and Lung Institute.

* * *

Taylor Manor Hospital in Ellicott City recently sponsored the **Second Annual Taylor Manor Hospital Psychiatric Symposium** held in the Lord Baltimore Hotel in Baltimore. The symposium was entitled "Discoveries in Biological Psychiatry", and featured distinguished internationally known speakers from the United States and across the world. Each speaker discussed his personal discovery of an important drug and biological therapy important in the care and treatment of the emotionally and mentally ill. The symposium was held April 17-19, 1970.

* * *



The Second Annual Taylor Manor Hospital Psychiatric Symposium held in April 1970 included the following 19 participants (first row, left to right): Harold E. Himwich, MD, Illinois; Tracy Putnam, MD, California; Raymond W. Waggoner, MD, Michigan, President of the American Psychiatric Association; Frank J. Ayd, Jr., MD, Baltimore city, Maryland; Irving J. Taylor, Ellicott City, Maryland; Gerald D. Dorman, MD, New York, President of the American Medical Association; and John F. J. Cade, MD, Australia. Pictured in the second row, left to right, are: Heinz E. Lehmann, MD, Canada; Hugo J. Bein, MD, Switzerland; Lothar B. Kalinowsky, MD, New York; Roland Kuhn, MD, Switzerland; Chauncey D. Leake, PhD, California; Albert Hofmann, PhD, Switzerland; and Joel Elkes, MD, Baltimore city, Maryland. The top row, left to right, includes: Barry Blackwell, MD, Ohio; Pierre Deniker, MD, France; Frank M. Berger, MD, New Jersey; Paul Janssen, MD, Belgium; and Stanley S. B. Gilder, MD, England. Seven other speakers also participated in the symposium but were not available at the time of this photograph.

The cooperation of physicians is requested in the referral of children with **Hand-Schuller-Christian disease** for a study being conducted by the National Institute of Child Health and Human Development's Reproduction Research Branch at the Clinical Center, National Institutes of Health, Bethesda.

Of particular interest for this therapeutically oriented study are children with manifestations of diabetes insipidus, or growth retardation of Hand-Schuller-Christian disease.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies should write: Peter Kohler, MD, or Griff T. Ross, MD, Clinical Center, N room 10-B-09, National Institutes of Health, Bethesda, Maryland 20014.

* * *

Martha Schipper, MD, child health consultant at the Frederick County Health Department, recently participated in a round table discussion on "Patient Motivation" held in Missouri.

Dr. Schipper was one of a group of physicians and other authorities from various parts of the country who contributed to this round table discussion. Their comments will serve as the basis for a future feature article in *Patient Care,* a medical journal.

* * *

The Division of Maternal and Child Health of the University of California School of Public Health at Berkeley announces postgraduate programs leading to the degree of public health. These programs are for pediatricians, obstetricians, and other physicians interested in receiving training in the field of maternal and child health.

Fellowship support is available, including basic support for the trainee, an allowance for dependents, tuition, and fees.

Applications are now being accepted for the group entering September 1971. For information, write: Helen M. Wallace, MD, School for Public Health, University of California, Berkeley, California 94720.

* * *

Edward L. Suarez-Murias, MD, FAPA, was recently the recipient of the 1970 Wisdom Award of Honor and has been elected to the Wisdom Hall of Fame.

The award cites Dr. Suarez-Murias as being "a distinguished and admirable American of high ideals, real intellectual integrity, and true wisdom".

Dr. Suarez-Murias received his MD degree from The Johns Hopkins University School of Medicine.

Presently, he is a psychiatrist at The Johns Hopkins Hospital and an instructor in psychiatry at The Johns Hopkins University.

* * *

Robert Howard Sauer, MD, of Silver Spring, has been appointed Clinical Director of Clifton T. Perkins State Hospital in Jessup.

* * *

Thomas E. Andreoli, MD, has been appointed Director of the Division of Nephrology, Department of Medicine, at the University of Alabama in Birmingham's School of Medicine.

Prior to this appointment, Dr. Andreoli had held a position at Baltimore City Hospitals.

* * *

W. Glen Moss, MD, has been named Deputy Associate Director for Extramural Research and Training in the National Heart and Lung Institute of the U.S. Department of Health, Education, and Welfare.

Along with his new duties in this newly-created position, Dr. Moss will continue to serve as Chief of the Hypertension and Kidney Diseases Branch.

Dr. Moss and his wife will live in Bethesda.

* * *

The increasing demand of the people of West Baltimore on emergency room facilities of **Lutheran Hospital** has prompted the institution's board of governors to employ several full-time licensed physicians to handle medical and surgical problems of the emergency unit.

Four of the physicians who became affiliated with Lutheran to work in the emergency room are: **Joel Goffman, MD,** formerly of the United States Public Health Service and a native Baltimorean; **Joseph Jack, Jr., MD,** an industrial physician with Bethlehem Steel; **Manuel Tan, MD,** of the Philippines, who has been with Lutheran; and **Jui-Chin Hsu, MD,** who came from Union Hospital in Elkton and is a native of Japan.

* * *

"Diagnosis and Management of Cystic Fibrosis", a 26-minute film, is currently available for free short-term loan to qualified professional groups from the National Medical Audiovisual Center, Station K, Atlanta, Georgia 30324.

* * *

Barry Byer, MD, has been appointed to the post of Health Scientist Administrator in the Training Grants and Award Branch of the National Heart and Lung Institute's Extramural Research and training branch in Bethesda.

In his new post, Dr. Byer will participate in the planning, evaluation, and administration of the Institute's diversified programs of undergraduate and graduate training in the cardiovascular and pulmonary fields.

* * *



A Past President Reports on the Semiannual Meeting

Mrs. Wallace H. Sadowsky

I have been told that there is nothing more passé than a past president. I have found that being passé does have its redeeming qualities though. Take, for example, my trip to Hershey and the Auxiliary's semiannual meeting. With no anxiety and no presidential responsibility, I was really able to enjoy it.

Forty-four women registered for the semiannual business meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland held Friday morning at Hotel Hershey, Hershey, Pennsylvania, September 11, 1970. Mrs. Raymond Yow, president, convened the meeting and Mrs. Robert Reiter, president-elect, recited the state auxiliary pledge.

Greetings from the Medical and Chirurgical Faculty were brought to the assembled physicians' wives by Paul A. Mullan, MD, Chairman of the Public Relations Committee. Dr. Mullan encouraged auxiliary members to assist the Faculty in all-out efforts to increase the enrollment in Maryland's two medical schools. According to Dr. Mullan, "Lack of medical school enrollment is a crisis . . . We should double our enrollment in the next year."

A roll call of officers, board members, and delegates followed. Mrs. William S. Stone reported that the reading committee had approved the minutes of the annual meeting held in April 1970. This was followed by the treasurer's report.

Mrs. Yow reported on her many activities since taking the office of president in April. She has held two meetings of the Executive Board; installed the officers for six component auxiliaries (Washington, Montgomery, Harford, Cecil, Wicomico, and Prince George's Counties); attended three meetings of the Program and Planning Committee of the Med-Chi Faculty; attended out-of-state medical auxiliary meetings in Delaware, New Jersey, and West Virginia; attended the 47th Annual Convention of the Woman's Auxiliary to the AMA in Chicago; attended visual and hearing screenings of three and four year olds in Talbot County; and availed herself of the Public Speaking Seminar at Med-Chi held last spring. Mrs. Yow also was guest at the annual luncheon of the Northampton-Accomack Counties of the Eastern Shore of Virginia held at the Massawadox Hospital, Massawadox, Virginia, in May. In October, she visited the Pennsylvania Medical Auxiliary at its annual meeting in Lancaster, the Fall Conference for presidents and presidents-elect in Chicago, and the Eastern Region Workshops in Philadelphia.

The following Nominating Committee to select a

slate of officers for 1971-72 was elected: Mrs. DeWitt E. DeLawter (Montgomery County), Chairman; Mrs. Thomas Craig (Washington County); Mrs. Allen Moulton (Allegany County); Mrs. Richard E. Lukes (Montgomery County); and Mrs. Robert Ensor (Baltimore County).

Announcement was made that the state-wide goal for auxiliary-raised funds for AMAERF is $6,000, with emphasis on the Student Loan Fund.

The Bylaws were revised by an unanimous vote to enable a physician's wife or widow to join any organized component auxiliary regardless of which county medical society her husband is a member of or may have been affiliated with.

The meeting was adjourned before 11 AM so the ladies could join their husbands in the Castilian Room for the program on "Environmental Pollution". An excellent presentation was given by Joseph A. Mihursky, PhD, Research Associate Professor and Chairman, Department of Environmental Research, Natural Resource Institute, University of Maryland. He spoke on "The Ecology and Condition of the Chesapeake Bay".

Franklin C. Daiber, PhD, Director of Marine Laboratories, and Professor of Biological Sciences at the University of Delaware, described "The Ecology of the Coastal Marshes". Jean J. Schueneman, BSCE, MPH, Chief, Division of Air Quality Control, Maryland State Department of Health and Mental Hygiene, spoke on "Air Pollution: Everybody's Problem".

Friday afternoon's program offered opportunities for many different activities: golfing, browsing in the gift shop, touring the chocolate factory, playing tennis, or even riding in a surrey.

I chose to join the Faculty on its conducted tour of the Milton S. Hershey Medical Center. I had taken the tour last year, but found that more of the building had been completed in the past year and that this year's tour revealed many new interesting facts as well as breathtaking views of modern innovations in hospital planning. The Center has an unique approach. Its concern with "family medicine" is the motivating force in establishing this new school, founded with a $50 million gift from the fortune of the late chocolate tycoon.

George T. Harrell, Jr., MD, is the dean. He designed the school "to educate dream physicians for tomorrow, physicians who will be up-to-the minute scientifically, yet deeply and humanly involved in the health problems of that neglected average American." This philosophy gave rise to Hershey's two greatest innovations: a clinical department of family and community medicine, and an academic department of behavioral science.

Each student is assigned to a family, who is under the regular care of a physician and has at least four members, one or more of whom have chronic illnesses or problems that keep the family close to its physician. For four years the student is on hand for each office visit, house call, or hospital admission involving the family. In this way, he will get to know the family members and to appreciate the continuity of their health problems. Eventually he will help the physician in the family's care.

As we followed our guide through the not-quite-completed hospital, being careful not to trip over boards, wires, and other obstacles of construction, we were amazed at the abundance of facilities planned for the hospital. We were shown ten operating rooms most modernly equipped; a radiology department on each patient-floor; a laboratory on each floor; and a modern kitchen with food carriers and special elevators which will enable everyone in the hospital to be fed within 45 minutes. We also saw motel-like rooms for self-care patients; electronic beds; luxurious lounges for visitors, patients, physicians and hospital personnel; and a Records Library with modern dictating equipment, data processing, and computer systems.

The reception given by the Wicomico County Medical Society around the beautiful fountain in the hotel's lobby followed. How proud Wicomico County physicians must be to have both the president of Med-Chi and the president of the Auxiliary from their midst. This lovely reception was to honor both Henry A. Briele, MD, and Mrs. Raymond M. Yow.

Mark Russell, the well-known humorist and pianist, provided the entertainment Friday night. His bipartisan jingles and political jokes were highlights of this semiannual meeting.

On Saturday morning, we heard U. S. Congressman J. Glenn Beall, Jr., whom the Maryland Medical Political Action Committee had arranged to present an informal discussion on legislation. We were also proud to hear George Finney, MD, give tribute to our Auxiliary member, Marian Mech, for her great contribution to MMPAC.

After Saturday breakfast, many of the women went on the conducted tour of the Hotel Hershey Gardens. Others chose to play tennis, badminton, or miniature golf, to explore the antique shops in the area, or to take the children to the amusement park. Some even chose to join their husbands at their specialty meetings. I enjoyed the panel discussion on "The Malpractice Problem: Insurance Coverage and Suits" at the meeting of the Maryland Chapter of the American College of Surgeons, and even found myself taking notes to pass on to my husband.

On Saturday afternoon, I joined the group taking the bus tour of the community of Hershey. The most outstanding part of the tour to many of us was the visit to Founders Hall, which had just been dedicated the day before. The hub of the Milton

Hershey School, Founders Hall is a complex of buildings comprising administrative offices, a magnificent reception area for visitors, a beautiful chapel and central auditorium, a banquet hall to accommodate 1,600 persons, a closed circuit television studio, and a social center for students, staff, parents, and alumni. Most of the people on tour with us agreed that in all of their travels through foreign lands and in other parts of this country, they had never seen a building so magnificent.

Saturday evening entertainment included a monologue on the Women's Musical Club delivered by Vandy Bauer, MC, and a skit written by Jeanne Sargeant with the musical accompaniment provided by Angela Linhardt. John Graham presented the introductions while Connie Galton, Ethel Biehl, Terry Bromwell, Norma Strobel, Peggy Bagley, Hilary Sargeant, and JoAnn Ptak made up the chorus.

Joseph Harrison, Med-Chi's comptroller, William E. Peterson, MD, E. A. Shimunek, MD, Raymond Yow, MD, Elmer Linhardt, MD, John DeHoff, MD, Talmadge Reeves, MD, Charles O'Donnell, MD, E. C. Mitchell, MD, Aaron Sollod, MD, and Phillip Briscoe, MD, all proved themselves to be hilarious pantomimists.

The reading of letters by Dee Banning and Nancy Reeves, and the delivery of impressions by Dick Bauer (especially that one of Jack Sargeant on the phone) both proved, as did all of the aforementioned entertainment, that amateur entertainment is often the best.

An innovation in this year's semiannual meeting was the Hobby Corner set up near the registration desk. It was interesting to note the many and varied hobbies and talents displayed by our physicians and families. From Allegany County, there were some ceramics, an arrowhead collection, a knit sweater, some beaded work, and a novel display of cooking utensils. Anita Bauer's crocheted afghan, Florence Oster's seascape, and Mary Miltenberger's crocheted dress drew much attention.

From Wicomico County, the Yow family displayed their hobbies of rug-hooking, costume-making, and the assembling of a Heathkit radio. Karen Carney's ceramics and Lilianne Burton's landscapes in water color were only outdone by Dr. Earl Beardsley's petit point and crewel work.

Montgomery County's talents were represented by Monica Ball's seascape and Dr. Carolyn Pincock's pictures with shells.

From Baltimore city there was a display to indicate Polly Reiter's interests in the DAR and the history of medical terminology. Edith Brantigan's collection of books on parliamentary procedure revealed her expertise in this field. Margie Warres' "Gifts from the Sea" was an artistic revelation of her seashore hobby. Attracting the most attention were the many works of E. A. Schimunek, MD, who displayed "Maryland Driftwood"—four pieces, each with an oil-painted scene, attached to an oar. Dr. Schimunek also displayed a duck of leaded glass and two very intricate, realistic paintings entitled "Eula's Hallmarks" and "The Doctor and His Hobbies".

From Harford County there was a beautiful needlepoint handbag made by Marge Garey. And from Prince George's County there were five lovely paintings done by Mrs. William R. Stecher.

Margaret Yow can be proud to have helped steer the 1970 semiannual meeting. But being passé personally helped to make it the most enjoyable meeting I have ever attended. Hotel Hershey was a serene and picturesque setting. The food was a gastronomical delight. The entertainment was lighthearted and gay. The activities were varied and plentiful and the camaraderie was warm. But above all, the educational programs were interesting enough to promote discussion and to make the semiannual meeting more than just another convention.

Health Careers in the Cumberland-Frostburg Areas

Information on health careers in the Cumberland-Frostburg area may be obtained from Elmer Hill, MD, of the Cumberland Health Department, John Moberly at the Memorial Hospital, Sister Mary Louise at the Sacred Heart Hospital, and the guidance counselors at any one of the nine high schools in the area as well as from the Cumberland Public Library.

The splendid laymen's magazine of the AMA, *Today's Health,* is to be found in the library of every high school in the area.

Health Career Clubs are in operation in all nine high schools and are instrumental in helping the student members receive first-hand observational experience from the physicians' offices and laboratories. Each club presents an award for the highest scholastic achievement to the outstanding senior student member of the club.

A series of slides has been made depicting the many avenues in health careers entitled "In Your Own Back Yard." These are available for use in the area.

A meeting was held November 10 to give the president of each Health Career Club an opportunity to learn from representatives of Allegany Community College and Frostburg State College what information is available from each college pertaining to the health field. A question and answer session followed the talks.

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Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.



Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives.There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

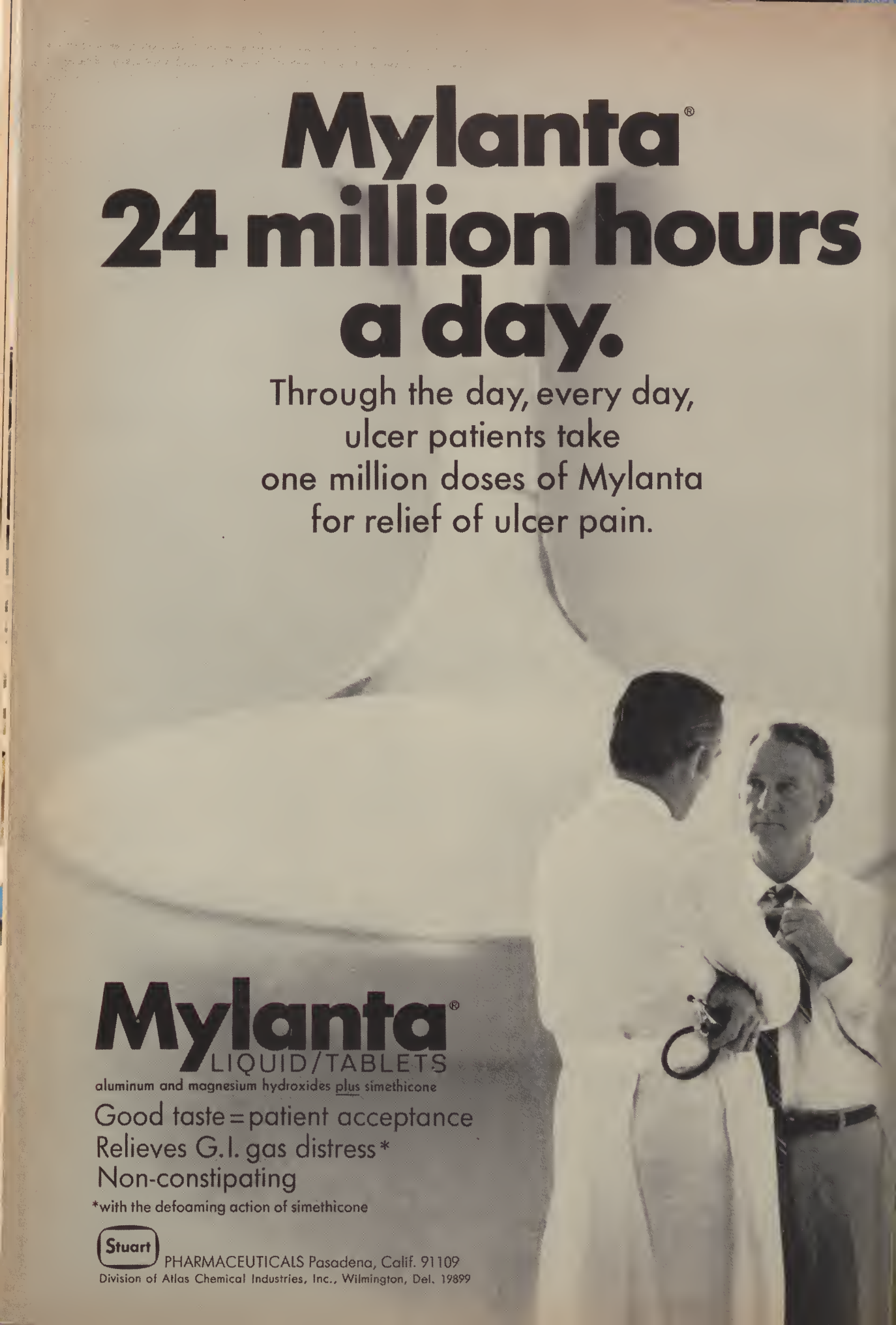
References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*: 267-279 (May) 1967. *2.* Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. *3.* Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. *4.* Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

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Baltimore County Medical Association

The members of the Baltimore County Medical Association enjoyed an "Afternoon at the Races" on Wednesday, August 26, 1970, at the Timonium Racetrack in Baltimore County. After a luncheon in the Challadon Room, the members adjourned to the reserved section of the grandstand to watch the races.

A beautiful trophy was presented to the owner of the winning horse in the eighth race by Wilmer K. Gallager, Jr., MD, president of the association.

According to J. Morris Reese, MD, chairman of the board of Timonium Racetrack, this is the first time that such an event has taken place.

Whether the members of the association won or lost, they all seemed to have a wonderful time and are looking forward to making this an annual affair.

September Meeting

Eighty members and guests were present at the September meeting of the Baltimore County Medical Association at Duffy's Restaurant.

Wilmer Gallager, Jr., MD, president of the association, presided at the meeting. The minutes of the previous meeting were approved and the treasurer, Herbert Levickas, MD, reported that the treasury was "in the black."

The Chairman of the Board of Governors, Theodore Patterson, MD, stated that the board approved the moving of the association offices to Sheppard Pratt Hospital at the expiration of our present lease.

John Krager, MD, vice-president, announced the dates and locations of the October and November meetings.

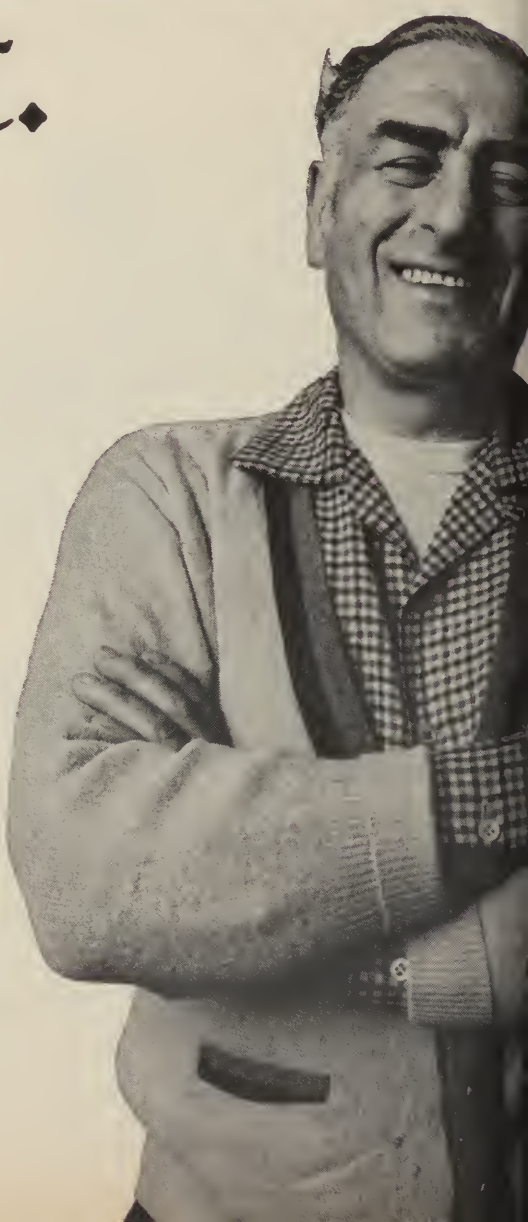
Ten new members were approved by unanimous vote. There being no further business, the meeting was adjourned.

B. B. Velez, MD, FACS
Chairman, Public Relations



Wilmer K. Gallager, Jr., MD, president of the Baltimore County Medical Association, presents a plate to Louis Kapelski, owner of the thoroughbred, Ruling Maxs, winner of the first Baltimore County Medical Association Purse on August 26, 1970 at Timonium. Jockey Danny Wright, standing between Dr. Gallager and Mr. Kapelski, rode Ruling Maxs to victory over the five and three quarter furlong distance in one minute, eleven and one fifth seconds. The lower portion of the picture shows Ruling Maxs nosing out Arm's Length, who came in second, and Plix, who took third place.

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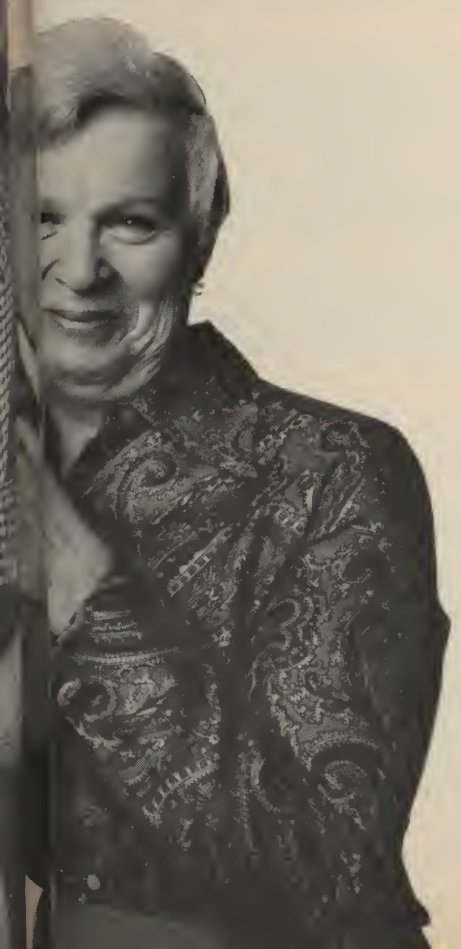


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Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

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NOVEMBER 20, 1970 — 12:30 PM

COMA—THE PHYSICIAN AND THE COMATOSE PATIENT IN THE EMERGENCY ROOM

Thomas J. Preziosi, MD
Assistant Professor of Neurology
Johns Hopkins University School of Medicine

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, November 23, 1970	12:30 PM
	Wednesday, November 25, 1970	7:30 AM
		9:00 AM
		2:00 PM

NOVEMBER 27, 1970 — 12:30 PM

RADIOGRAPHIC AND RADIOISOTOPIC PROCEDURES IN THE EVALUATION OF NEUROLOGICAL PATIENTS

Giovanni Di Chiro, MD
Section on Neuroradiology
National Institutes of Health

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, November 30, 1970	12:30 PM
	Wednesday, December 2, 1970	7:30 AM
		9:00 AM
		2:00 PM

DECEMBER 2, 1970 — 8:00 PM

MANAGEMENT OF ULCERS

David B. Skinner, MD
Assistant Professor of Surgery
Johns Hopkins University School of Medicine

Thomas R. Hendrix, MD
Professor of Medicine
Johns Hopkins University School of Medicine

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Friday, December 4, 1970	12:30 PM
	Monday, December 7, 1970	12:30 PM
	Wednesday, December 9, 1970	7:30 AM
		9:00 AM
		2:00 PM

DECEMBER 11, 1970 — 12:30 PM

TEMPORAL ARTERITIS AND CATARACTS

Richard D. Richards, MD
Professor and Head
Department of Ophthalmology
University of Maryland School of Medicine

Sponsor: ST. AGNES HOSPITAL

Replays:	Monday, December 14, 1970	12:30 PM
	Wednesday, December 16, 1970	7:30 AM
		9:00 AM
		2:00 PM

DECEMBER 18, 1970 — 12:30 PM

DRUG ABUSE—THE BARBITURATES

Joseph R. Bianchine, MD
Assistant Professor of Medicine
Johns Hopkins University School of Medicine

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Replays:	Monday, December 21, 1970	12:30 PM
	Wednesday, December 23, 1970	7:30 AM
		9:00 AM
		2:00 PM



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MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAYS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

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Presentation of Cases 7:30 PM

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Easton Memorial, Easton
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Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
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Keswick, Baltimore
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Physicians Memorial, La Plata
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St. Agnes, Baltimore
St. Joseph, Baltimore
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Sinai, Baltimore
Union Hospital of Cecil County, Elkton
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Washington County, Hagerstown

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For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
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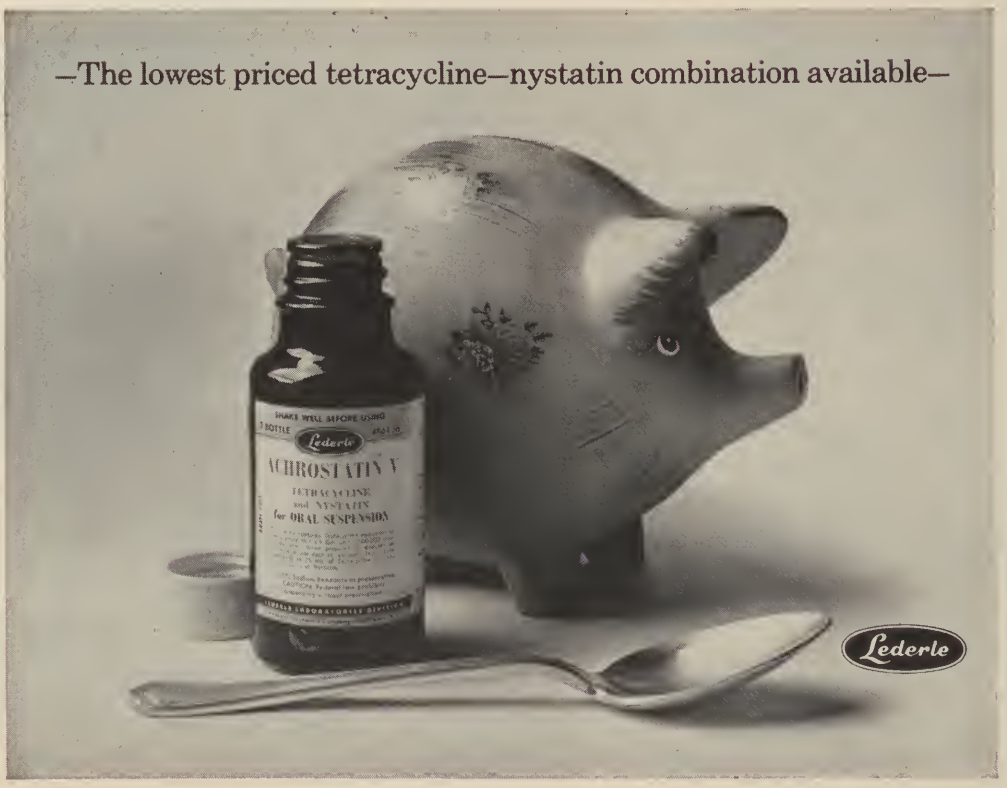
IMPORTANT NEWS

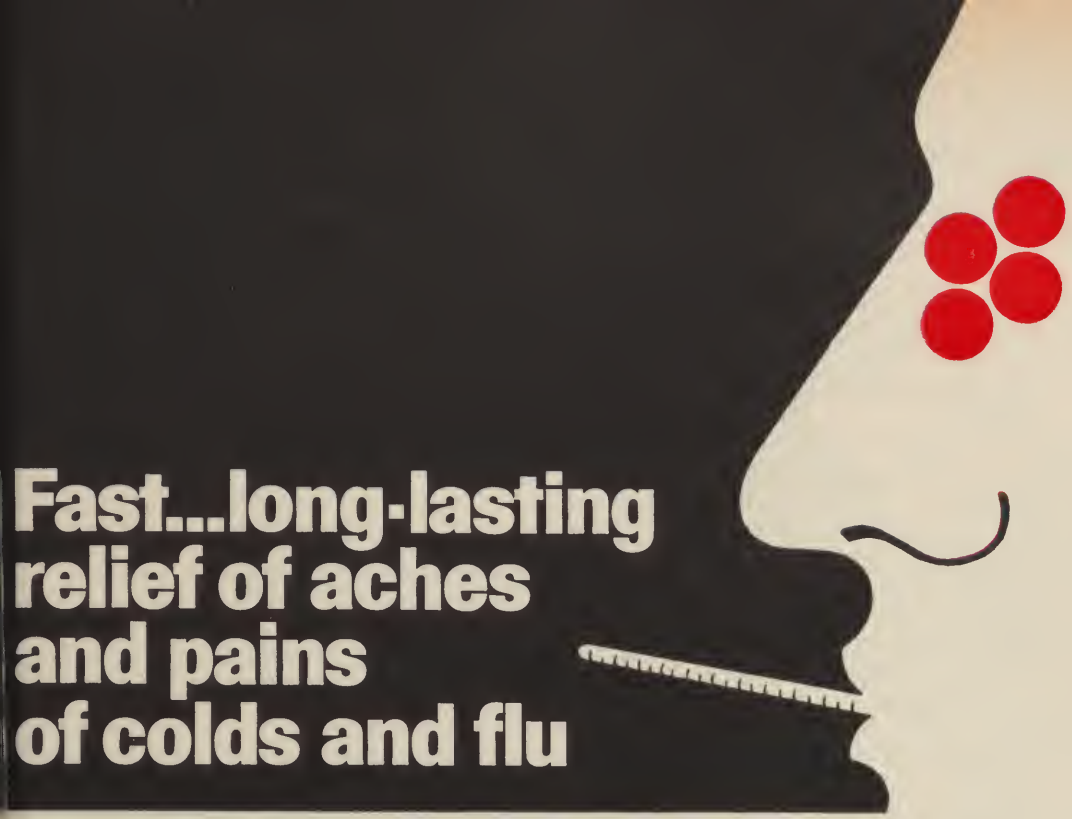
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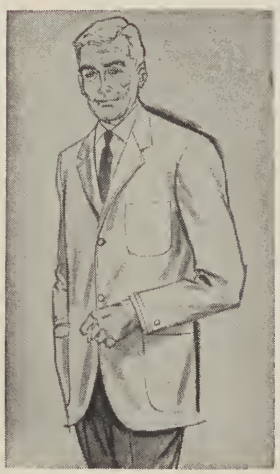
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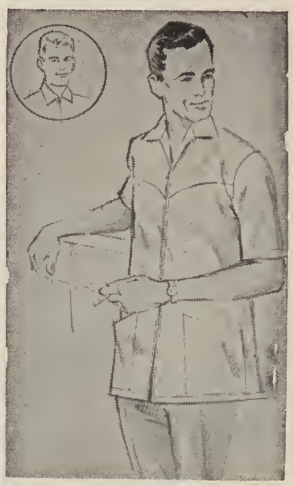
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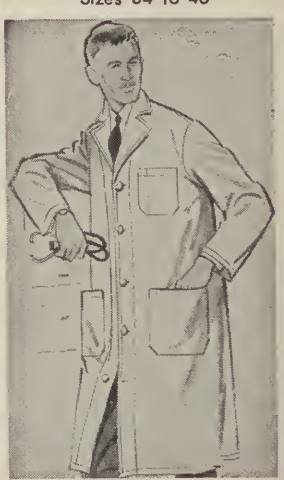
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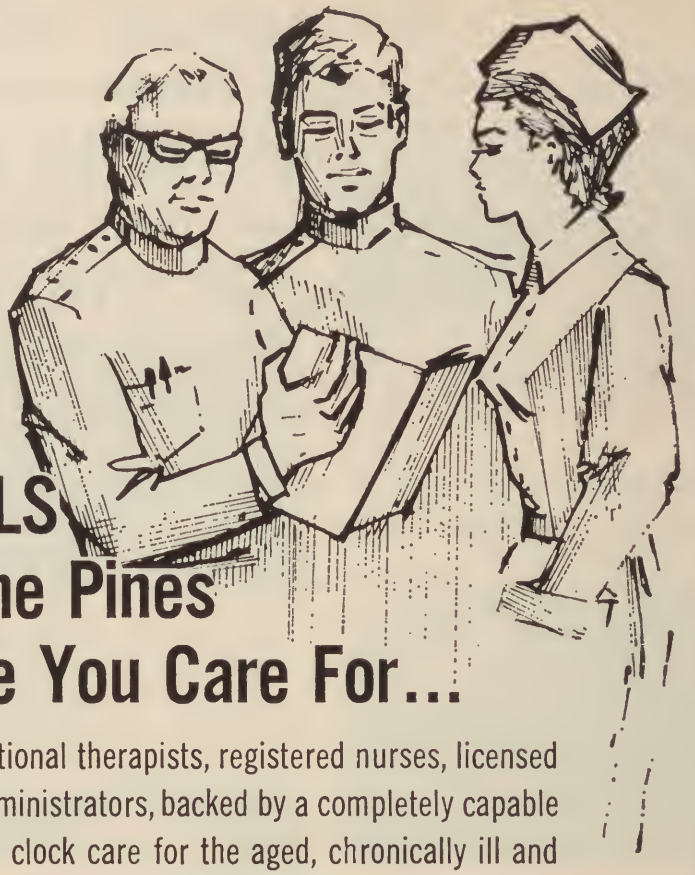
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A dinner-dance with Rivers Chambers Orchestra
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"Singing is Better Than Any Dope"











Janis Joplin, Jimi Hendrix, and Diane Linkletter. What did these three people have in common? And anyway, you are probably asking, who were they?

In answer to the first question, these three people had death by drugs in common. Each ended his own life by taking drugs. Each was under 30 years of age.

Janis Joplin sang the blues. At age 27, she had inscribed a name for herself in the hearts of young fans who "dig soul". While she declared, "Singing is better than any dope", still she died of an overdose of heroin only last month.

Three weeks before her death, Jimi Hendrix, also 27, died. This original blues guitarist suffered a more ignoble death. He choked on his own vomit after taking nine sleeping pills. At the much-publicized Woodstock Festival held in the summer of 1969, he delivered a surrealistic, anguished version of the "Star Spangled Banner", that still elicits praise from blues fans and critics alike.

Diane Linkletter was the youngest daughter of Art Linkletter, a show business veteran of 35 years. She, too, took her own life in a mood of irrationality, panic, and despair that was the aftermath of a bad LSD trip.

Each of these young people were successful, yet each developed a reliance on narcotics as a way of life—and death.

But, why should they have developed this reliance? Why should anyone?

Certainly, we live in a highly complex and pressure-filled society. Just as these three young people mentioned above felt themselves under pressure for individual reasons, students are also under pressure to get good grades. Housewives are under pressure to successfully manage family, home, and job. Executives are under pressure to "close the big deal". Truck drivers are under pressure to stay awake. GI's are under pressure to accept discipline. Everyone is pressured nowadays to have, to do, or to be.

To ease the pressure, or else to stimulate a response to it, marijuana is puffed, pills are dropped, and heroin is mainlined.

In this issue of the *Journal,* many possible answers are supplied to solve the drug problem. Harvey Gollance, MD, explains his Methadone Maintenance Program. Delegate Sklar and Judge Ross call for stricter law enforcement. Mr. Lichtman, a former drug user, explains his mainlining experiences. And Neil Solomon, MD, PhD, calls for communication through education as a way of undermining the drug problem.

From all of these excellent articles, Dr. Solomon's emerges as the one that deserves special comment. The others emphasize the rehabilitative aspects of the problem. Dr. Solomon's stresses the preventive aspect.

Communication through education seems a simple formula to this complex problem, and the most sensible one offered to date.

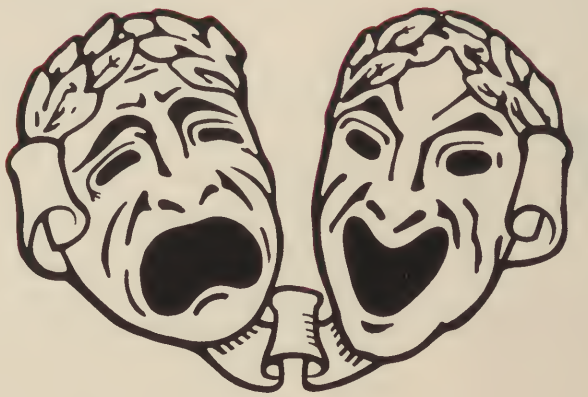
Perhaps if students, housewives, executives, truck drivers, GI's, and society members in general could learn about drugs, they could better compare the extent of their pressures to the risks of taking drugs. Logically, after weighing their pressures against the effects of the drugs, these individuals would choose to shun the drug subculture. For example, they could communicate to others the uselessness of taking drugs in solving any problems, just as Dr. Solomon suggests.

Perhaps, too, if a program of two-way communication through community education is developed, the future Janis Joplins of this world would say that, "Singing is better than any dope", and mean it.

CKW

In a world that is constantly changing, man is seeking real meaning in life. However, he has always looked for ways to escape from the frustration and disillusionment that faces him. He may use drugs in a very genuine attempt to cope with this disillusionment and despair. But, by using drugs, he is merely fleeing from one type of commitment, often recognized as false and built on deception and steeped in constraint, into another type of commitment. This new commitment appears to be a new freedom, but it may often end in a new slavish entrapment and a new lie. His quest for real meaning all too often ends in a new, even more pervasive illusion.

Why People Take Drugs: Escape and Search



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Throughout history, man has always attempted to escape from the intolerable and seek that which he wants and dreams of. One means of bridging this gap between frustration and fantasy was magical rituals. Delusions in the form of individual or shared mythologies were another. Drugs were a third ancient form of transcending the limitations of disappointing reality and of reestablishing the shattered illusions. This transcending was proclaimed as a trip towards the true reality, the "beyond", which left the limited, sober, alienated presence behind.

Drugs in History and Literature

Kannabis, a Greek word of Iranian origin, is related to the Greek word konabos (noise) which refers to the ecstatic behavior induced by marijuana, and described by Herodotus in celebrations of the Scythians.

Opium was known to the Sumerians as a plant of joy. Wine, beer, and mead were used by the Europeans; peyote and psilocybin by the American Indians; soma by the Aryans at the time of the Vedas; and the mushroom *Amanita muscaria* by the Siberian shamans. These were all means to lead the user to a state of ecstasy or forgetting, and to what the Greeks called "enthusiasmos"—being filled by a godly force. Even Socrates said, "Our greatest blessings come to us by way of madness," (*Phaedrus*, 244A), although certainly he did not think of the use of drugs to bring about this inspired state.

We find two references to the use of a tranquilizer and a narcotic in Homer's *Odyssey*. In book IV (220 ff), Helen "drugged the wine with an herb that overcomes all grief (nepenthes) and anger and lets

forget everything bad. Whoever drinks wine thus drugged cannot shed a single tear all the rest of the day, not even when his father as well as his mother die, or when he sees his brother or son hewn in pieces before his eyes." In book IX (90 ff), Homer writes about the landing on the island of the lotus eaters and the effect of the fruit of the lotus tree, "which was so delicious that those who ate of it left off caring about home, and did not even want to go back and say what happened to them." Tennyson (*The Lotus Eaters*) asks:

"Why are we weigh'd upon with heaviness,
And utterly consumed with sharp distress.
While all things else have rest from weariness?
All things have rest: why should we toil alone,
We only toil, who are the first of things,
And make perpetual moan,
Still from one sorrow to another thrown . . ."

And he answers:

"We have had enough of action, and of motion we . . .

Let us swear an oath, and keep it with an equal mind,
In the hollow Lotus-land to live and lie reclined
On the hills like Gods together, careless of mankind . . .

Surely, surely, slumber is more sweet than toil, the shore
Than labor in the deep mid-ocean, wind and wave and oar;
O, rest ye, brother mariners, we will not wander more."

Question and answer, the escape from toil and the quest for peace: we see in this poem the two poles of the one experience—the flight from something unacceptable towards something better.

Underlying Reasons for Using Drugs

If we try to answer the question: "Why do people take drugs?" we can say that they either want to escape from or to fight against something, or else they want to search for something else, something new and better. All drug abuse can be explained by this general law of escape and quest, though the emphasis may vary.

If we ask our patients what they flee from, they tell us in descending frequency: boredom and a sense of meaninglessness; a lack of identity and a sense of not belonging; anger and guilt; a sense of worthlessness; emptiness and shame; and general frustration and tension. What is sought are the opposites: meaning and satisfaction of "curiosity"; a sense of self and of belonging; quiet and peace; a sense of worth and richness; and relief and pleasure.

Thus, it is clear that the use of any mind-altering drug is a symptom of an underlying problem, and not the problem in and by itself. Too little is being done in an attempt to understand the underlying causes of drug abuse and to treat its consequences. Drug abuse is viewed as if it were enucleated from its causes and its effects. It is made into a demon and is attacked with a moral indignation which leaves the fighter tired, but guilt-free and with a sense of power.

Of course, reality is far more complex. I have divided the underlying polarity of escape and quest into four dimensions: 1) the individual and his inner conflicts; 2) the family background; 3) the social condition; and 4) the philosophical value problem involved.

The Individual's Inner Conflicts

I believe that there are three particular conflicts which are especially relevant to understanding and treating the individual drug user. The first concerns the formation of conscience and ideals. If we are confused about responsibility, integrity, and commitment, if we see a profound abyss between that which we demand and expect from ourselves and that which we really are, we try to bridge this gap. In place of the disillusionment with ourselves, we reestablish, through the use of drugs, the illusion that we are happy, great, rich, all-powerful, magically perceptive, and blessed.

The second conflict is peculiarly modern. Instead of developing an active attitude towards the world, we develop a particularly passive, receptive attitude which conflicts with the extremely active mobile style of life expected of modern man. I strongly suspect that there is a correlation between the dependency upon the TV during the formative years of childhood, and the peculiarly demanding, gaping attitude which leads many youngsters into drug dependence.

The third conflict is not specific for the present. The wish to be magically omnipotent, and the realization that one cannot be, are polar to each other. Drugs wipe out bad reality just as the wand of the magician does.

Family Background

All children have to outgrow their parents, have to break away from their family, and have to go through the often painful process of disillusionment. This is what adolescence is all about. Today's preferred way of carrying out this break is through drugs—if they are available and if the social setting is conducive to it. If we look more closely at the relationship with the family, we recognize the same loss of commitment and authority within the family as we just encountered within the individual. Beyond this we often find a very profound disillusionment and distrust.

Perhaps I am mistaken, but I believe that this disillusionment is much more pervasive today than in the past. I suppose this is so because of the split between the enormous technological power on the one

side and the emotional dearth, the scarcity of ideas, and perhaps most centrally, the lack of integrity of the adult world on the other. We adults resemble the giant in Nebuchadnezzar's dream. We are world shaking, but with clay feet. Each one of us has access to the magical wonders mankind has been dreaming about for millennia. Yet many of us have not grown far beyond the temper tantrums and dependencies, the arrogance and vindictiveness, the self-aggrandizement and the power hunger of the toddler years.

Within a particular group, the target of the youngster's rebellion may be the lack of responsibility at home and the possessive attitude of his parents. As one youngster in our program told Dr. Berman: "Look, I don't blame anything on my parents or on any of the parents because they are doing it unknowingly. They are doing it out of love and the feeling that they are doing the best thing. But the kids want to get out on their own, but they (the parents) don't want the kids to go out on their own. They want him to stay at home and they want to support him until he is 21. A lot of people I know just aren't interested in doing anything because they have everything, like when you have a car and you have everything you don't have to work for anything. . . ."

Other adolescents rebel against the unreasonable but frequent alternation of parental rage and nagging with a spoiling and indulgent chumminess. They protest by doing that which they know would elicit the most attention from their self-centered parents —using drugs.

In another group of adolescents—perhaps the most frequent group—a nice, basically healthy adolescent teases himself and his conforming, perhaps rigid parents by experimenting with drugs. He tries to test whether the precepts of his parents should be believed, or whether his peers were right after all. The dreary thing is that most communication about drugs from the older generation is such a huge lie that the parents cannot be trusted anymore, once the youngster has found this out.

Still others say that they seek their own identity and integrity against the dishonesty and the lack of openness and trust at home by using drugs. If the parents are away all the time seeking status and success, the child seeks a new integrity in a life style which is diametrically opposed to that of his parents.

Finally, if we look at the slum family, we often find a pervasive lack of structure, discipline, mutual concern, and respect. But this is basically the same absence of limits and true authority as is found in many middle and upper class families.

In general, we might say that during the inevitable rebellion of adolescence, if the commitment to a close person is profoundly betrayed, it is replaced by a commitment to a thing, namely, a drug.

The Social Condition

If we turn now to the social environment, we can no longer solely place the blame for drug abuse on the "horrid pusher who seduces innocent children". This demonic figure only rarely plays any role in the genesis of drug abuse. He is the profiteer, not the causation. Socially, the group who uses drugs has to be the focus of the problem. Where there is not a mature, adult community and only a weak sense of belonging, the adolescent may adhere to one of the drug cults or a "groovy group" that lends to the member a sense of solidarity, a mutually confirmed identity.

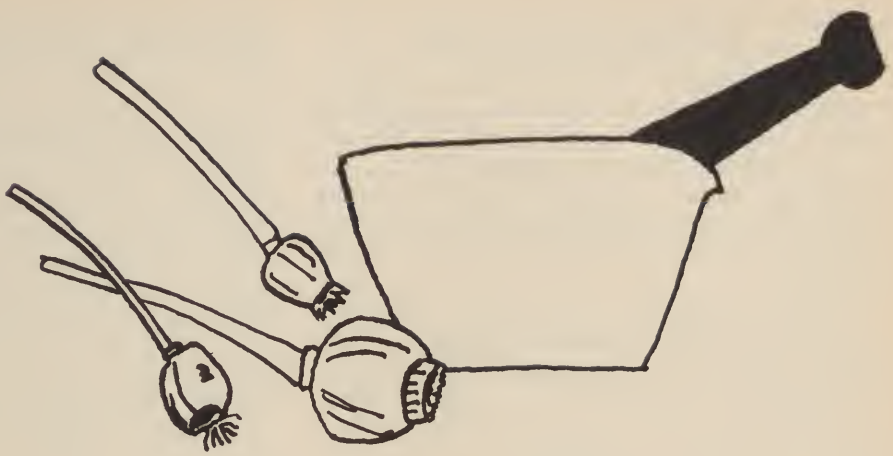
When the prevalent values of society are success, prestige, and goal-oriented pursuits, a new integrity is found in the negation of these values. Instead of the "wheeling and dealing" combined with the commercialized, noisy, competitive way of life, the individual looks for genuineness and tranquility, for serenity and introspection. When faced with a technological Babylon with an overwhelming amount of laws, tasks, and prohibitions, he rebels by disobeying these laws, limits, and conventions. And when he sees in progress "a shameless boasting about a high standard of low living", as the historian H. J. Muller has called it, he flees into a more simple, drifting but seemingly more sincere way of life.

On the other hand, in the jumble of the slums, the addict is often a hero. The "slick cat" is the successful man who has beaten the hated establishment. The quest for heroin is the quest for an identity and for a meaningful life. The deeper meaning of "hustling" lies in the "gratification of accomplishing a series of challenging, exciting tasks, every day of the week," according to Preble and Casey.

The Philosophical Problem

We find in today's culture a general resistance toward asking the basic philosophical questions of meaning and value. Instead, we see an unreflective activism and pragmatism. The contemplative search for a perspective is scorned, or simply forgotten. True philosophical questioning is rare. This betrayal of philosophy is reflected in the various mysticisms, now not less rampant than the profound value blindness of those caught in the "rat race".

In his search for real meaning in life, man has tried and experimented with many things in an attempt to flee from the frustration and despair, the delusions and disillusionment that face him. If he turns to and uses drugs in a genuine attempt to cope with this situation, he will merely be trapped into a new lie and an even more pervasive illusion. He is still left with his problems, and he must once again begin his search for meaning in life.



Treatment of the Opiate Addict in Maryland

Does the General Hospital Have a Role?

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The Maryland Drug Abuse Law, passed in July 1969, created a state authority which was given the responsibility for the supervision and support of treatment programs for opiate addicts. The concern that programs developed by the authority provide the best possible care for the addict raises the question of the role of the general hospital in the rehabilitation and treatment of the opiate addict.

Up to now, the general hospital has played a most insignificant role in the long-term treatment of the addict. What contact there has been has concerned itself with the treatment of the acute side effects of addiction, ie, hepatitis, bacterial endocarditis, etc.[1]

The Past Role of the Physician and the Hospital

The medical profession has generally been excluded from the treatment of opiate addiction since shortly after the passage of the Harrison Narcotic Act of 1914. This exclusion has occurred not primarily because of the law itself, but rather through restrictive regulations developing subsequent to the passage of the law.[2] The constraints put upon the physician's ability to treat the addict, and the series of prosecutions resulting from such attempts, have effectively insulated the practicing physician from any meaningful therapeutic contact with opiate addicts.

Training in this area in the medical schools has been inadequate, thus increasing the general reluctance of physicians to become involved with the treatment of the opiate addict.

Closely paralleling the addict's inability to secure care from his personal physician has been the addict's inability to use the general hospital as a place to receive long-term care for his addiction. Addicts coming to general hospitals seeking medical care are

almost invariably referred to state or federal institutions or are even turned over to the police.

The institutions to which the addict is referred can be considered divorced from the mainstream of medical practice. Neither the practicing physician nor the medical student has occasion to come into any but the briefest contact with either state mental hospitals or federal institutions such as the United States Public Health Service Hospital at Lexington, Kentucky.

The fears of legal reprisal, the paucity of information and teaching, the very limited therapeutic success (until recently) of those specializing in the treatment of opiate addicts, together with the general feeling of society that the opiate addict is a criminal rather than a sick person, have combined to prevent the addict from using either the practicing physician or the general hospital for long-term care.

Treatment Facilities in Maryland

The actual number of addicts in Maryland is unknown. As of December 31, 1968, the Federal Bureau of Narcotics and Dangerous Drugs disclosed that there were 1,940 active recorded narcotic addicts in the state—1,765 of whom lived in Baltimore. Unofficial estimates have placed the total number of opiate addicts in the state at about 5,000.

The ambulatory treatment facilities available in the greater Baltimore area, where most of the addicts are thought to live, are very limited. The three major treatment programs now functioning are: The Johns Hopkins Hospital Drug Abuse Program, Provident Hospital's Project ADAPT, and Man Alive, Inc. Together, these three programs jointly care for less than 1,000 patients. The state program at the Baltimore Narcotics Clinic is limited to patients on probation and has a current enrollment of about 100. A few other programs care for a handful of patients.

Until recently, the treatment of the opiate addict was felt suited only to inpatient facilities and the use of ambulatory services, for such treatment was officially frowned upon.[3] This stand, however, has been challenged due to the work of Dole and Nyswander, who use the synthetic opiate methadone for so-called hard-core opiate addicts.[4,5] Although they originally required that their patients undergo a six-week period of hospitalization for regulation on methadone prior to the beginning of ambulatory care, this six-week period is no longer mandatory except for the most socially and medically disabled addicts. Their experience has shown that while some addicts will need prolonged hospitalization because of concomitant medical or social illness, the majority of patients can be safely treated in an ambulatory setting.

The General Hospital

There seems to be little reason why the ambulatory setting needed for the long-term treatment of opiate addicts could not be provided by the general hospitals in the area. Several hospitals have participated in the Dole-Nyswander program in New York city and have added important ambulatory treatment resources to the care of the opiate addict.

In many urban areas today, the problem of opiate abuse has become a major community health problem. Many local hospitals have indicated a special interest in the medical problems of their surrounding communities. To the three usual major functions of hospitals—patient care, research, and training—a fourth function, care for community health problems, has become evident. General hospitals providing treatment facilities for this major community health problem would be a proper step forward in meeting the social-medical needs of the surrounding community.

One could anticipate positive results from the incorporation of local general hospitals into a regionally planned treatment program for opiate addicts.

1. The treatment of the opiate addict would join the mainstream of medicine. Practicing physicians, medical students, and medical workers below the physician level, would have an opportunity to participate in and learn about the problems and treatment of opiate addiction. Such treatment should not be restricted to the methadone approach only but ought to include the use of other drugs and techniques.
2. Hospital outpatient departments, grossly underutilized, could be used during off-hours for the ambulatory treatment of opiate addicts. This would save the expense of establishing such facilities in new institutions.
3. Professionals needed for the comprehensive treatment of opiate addicts, ie, psychiatrists, internists, public health nurses, and social workers, are already available in the general hospital setting. Increased numbers of personnel could be easily incorporated into already functioning departments.
4. The acceptance by the general hospital of the opiate addict as a patient with an illness would influence both society's view of the opiate addict and the opiate addict's view of himself.
5. The opiate addict would be able to secure treatment from a facility reasonably close to his home. This would do away with the need of traveling long distances to secure treatment.
6. The image of the general hospital in its community would be enhanced by the hospital's willingness to undertake treatment of a problem of great concern to many members of the community.
7. Involvement of general hospitals in treatment programs would foster clinical trials and ex-

perimentation within a given region and could help prevent excessive central bureaucratic control.

Coordination of Services and Inpatient Beds

For medical care delivery and research to be most effective, the various hospital clinics established around the metropolitan Baltimore area should be closely linked. One approach would be the establishment of a central coordinating agency which would both advise the various hospital clinics and standardize data collection. Then, programs would not work at cross purposes and the data collected from each program would be useful for research purposes. The Drug Abuse Authority should play this role.

Because of the cost and inappropriateness of using expensive general hospital inpatient facilities for those patients needing more intensive treatment of their addiction than can be given in an ambulatory area, a facility or facilities with live-in capabilities should be available to all of the general hospital clinics. Patients requiring more intensive treatment of their addiction problems could be referred from the hospital clinic to the live-in facility and then, when appropriate, back out to the hospital clinic. Levels of care appropriate to the addict's needs should be available in this facility. Addicts needing those in-patient hospital services that the general hospitals do provide should have access to them like any other patient.

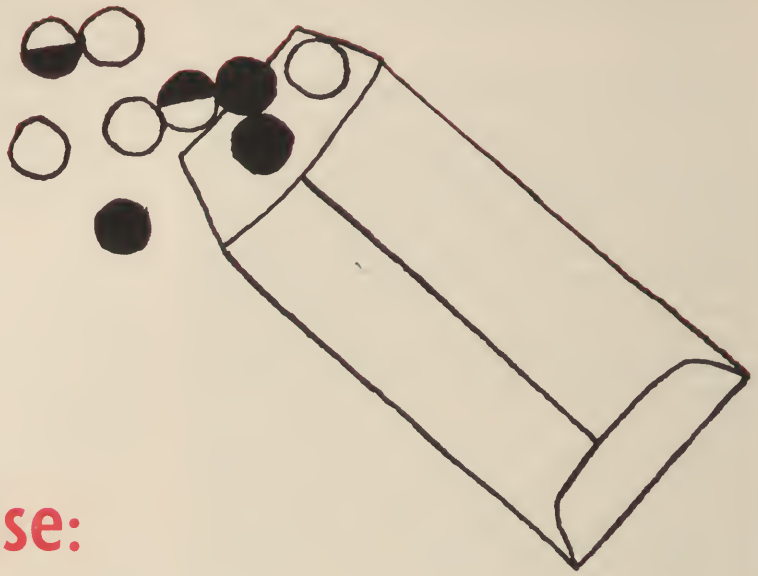
Conclusion

Traditionally, general hospitals have avoided the opiate addict and have taken little or no role in the long-term care of these patients. Changing therapeutic techniques and the willingness of many general hospitals to develop medical programs based on community need now make it appropriate that general hospitals contribute resources to the treatment of these patients. Such involvement would have numerous advantages.

For proper collection of data and for coordination of activities, a central agency, such as the Drug Abuse Authority, should be used. A live-in facility should be available for those addict patients needing more intensive treatment for their addiction.

REFERENCES

1. Sapira, J. D.: The narcotic addict as a medical patient. *Amer J Med* **45**:555, 1968.
2. Lindesmith, A. R.: *The addict and the law*. Vintage Books, New York, 1965.
3. Narcotics Addiction: Official actions of the American Medical Association, published by AMA, 1963.
4. Dole, V. P., Nyswander, M. E., and Warner, A.: Successful treatment of 750 criminal addicts. *JAMA* **206**:2708, 1968.
5. Progress report on evaluation of methadone maintenance treatment program as of March 31, 1968: Methadone Maintenance Evaluation Committee. *JAMA* **206**:2712, 1968.



Drug Abuse:

The Dangers and Responses

Harvey Grant Beck Memorial Lecture

The following papers and remarks were presented as a panel discussion during the 1969 Semiannual Meeting of the Medical and Chirurgical Faculty. The panel was held in the Hotel Hershey, Hershey, Pennsylvania, on September 5, 1969.

Russell S. Fisher, MD, President of the Faculty, presented the opening remarks and introduced the panel members.

The Harvey Grant Beck Memorial Lecture is supported by an endowment to the Medical and Chirurgical Faculty. Members of the panel who will present this lecture on "Drug Abuse: The Dangers and Responses" include Louis J. Kolodner, MD, who will serve as moderator; Honorable David Ross, a judge on the Supreme Bench of Baltimore city; Mr. Steven V. Sklar, a delegate to the General Assembly from the 5th Legislative District of Baltimore city; and Harvey Gollance, MD, Associate Director of the Beth Israel Medical Center and the Administrator of the Methadone Maintenance Treatment Program in New York city.

Louis J. Kolodner, MD, the panel moderator, opened the discussion with the following introductory remarks.

There is presently a malignant type of medical-social plague threatening us and adversely affecting considerable numbers of our young adults, all potentially good and useful citizens from all walks of life. The drug addiction problem is producing social, economic, psychiatric, somatic, and educational havoc in the affected individuals. Drug abuse prevention and treatment deserve to be given paramount consideration in our society today, and this problem deserves the attention and cooperation of every citizen, every physician (regardless of his specialty) and of John Q. Citizen in general.

Drug addiction reduces the productivity of many thousands of people in the United States annually. Effective educational, medical, judicial, legislative, and law enforcement measures should be initiated and sustained in order to prevent and treat this threat to our youth and to the very foundation of our country.

Dedication, organization, perseverance and, most of all, adequate funds from the city, state, federal, and private sources are needed.

The destruction of families and homes is appalling, and the loss to industry and business each year amounts to many, many millions of dollars, all because of drugs.

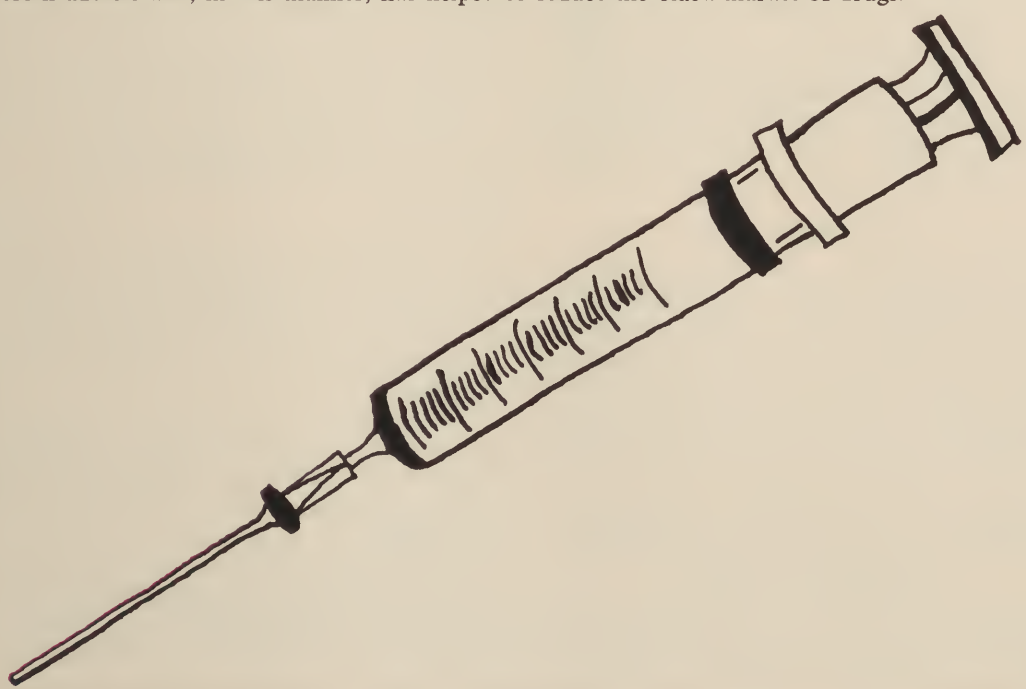
The Medical and Chirurgical Faculty of Maryland has been vitally interested in and is vigorously pursuing this problem of drug abuse and drug addiction and its prevention and treatment. The society has conducted an in-depth study of facilities for treating drug addiction in Maryland, particularly in Metropolitan Baltimore. It has also visited and studied New York's drug addiction treatment centers.

The Faculty has also set up guidelines for the treatment of drug addiction in Maryland.

In addition, this society has also recommended that treatment centers be located at or nearby properly equipped hospitals.

The society feels that all methods of treatment should be used to treat drug addiction, ranging from abstinence with psychiatric and social service guidance, to properly controlled and medically supervised use of blocking agents. It has approved the proper use of methadone blocking and the enforcement in the treatment of hard-core heroin addiction. I think it is one of the few, if not the first of the societies that has come out in this manner.

Finally, the Medical Faculty has established excellent liaison with the United States Department of Narcotics and Dangerous Drugs, as well as with law enforcement agencies. Med-Chi has interviewed and restrained individual physicians from unwise and indiscriminate treatment of heroin addicts and, in this manner, has helped to reduce the black market of drugs.



There are essentially two ways that drug abusers and drug addicts come before the criminal courts. Violating our narcotic laws, either through the sale or possession of prohibited narcotics and its accompanying paraphernalia, is the first way. The other way is through committing crimes to support the drug habit or to finance the purchase of illicit drugs. Addiction itself is not a crime, and under our Federal Constitution the states are prohibited from making it a crime.

Drug Abuse and the Courts

THE HONORABLE DAVID ROSS
Judge
Supreme Bench of Baltimore City
Baltimore

In the criminal court we deal with individual defendants on a case-by-case basis. Looking at it from that point, I am not able to ascertain from my own personal experience, nor have I been able to satisfactorily ascertain from what meager statistics are available, just how large the problem of drug addiction is in our own city of Baltimore, the state, or the country. You hear many conflicting stories, many different figures. However, from what I have seen dealing with it on a case-by-case basis, day to day in the criminal court, I am willing to accept the statement of Robert E. Farber, MD, Baltimore City Health Commissioner, that drug abuse is a major public health problem in Baltimore city.

I would also add that the drug problem is a major crime problem, not only because possession and sale of narcotics and possession of narcotic paraphernalia are crimes, but because of the large number of crimes which are committed to finance the purchase of narcotics. You usually hear a habit referred to in terms of dollars a day. It can run anywhere from $15 to $100.

Financing the Habit

Almost invariably the habit is financed through crime (ie, robbery, burglary, armed robbery, and forgery). If the theft is one of money, there is usually a direct correlation between the amount stolen and the cost of supporting the habit. If the theft is one of stealing property, such as a television set, it must be three to five times as much in value as that which the addict needs to support his habit.

If an addict has a $100 a day habit, he must steal at least $300 worth of property a day to finance it.

Determining the Verdict

What part does a criminal court play in the drug abuse problem? First of all, we receive the cases, and the charges stated in them. We have to determine the guilt or innocence of each particular defendant. This is done either by a jury or by the judge, depending on the election of the defendant. In Baltimore city, it is usually the judge who hears the case. We have a very small percentage of criminal jury trials here.

I subscribe to the view frequently stated by judges that deciding guilt or innocence is relatively easy when you compare it with the problem of deciding what to do with the defendant after his guilt has been established.

Under our system of law, the state has the burden of proving a defendant guilty beyond a reasonable doubt. On the question of guilt or innocence, if there is a reasonable doubt as to guilt, then the verdict must be—not guilty. But if you find the defendant guilty, you must then make disposition of his case. You must either send him to prison or place him on probation, and this is where the difficulty begins.

Any case is difficult and it is particularly difficult when you are dealing with a drug user or a drug addict. The primary goal in sentencing is to protect the public.

In order to protect the public, we subscribe to the theory of deterrence. We either try to deter the defendant from committing the same crime again or we try to deter others from committing similar crimes by using the defendant as an example in sending him to prison.

We also believe in the value of rehabilitation. If you can take a criminal and turn him into a useful member of society, then you have cut down the criminal population by one, in any event, and society is protected.

To help illustrate some of the heartaches and difficulties that go into disposition of cases involving drug users and drug addicts, I am going to refer briefly to two cases which I think exemplify the problem.

Case 1

The first case involves a man who was found guilty of possessing narcotics and narcotic paraphernalia. He was sentenced to prison. He requested immediate disposition following the determination of guilt. However, at the conclusion of the case and after his sentence was imposed, I advised him and his counsel that if I could be shown there was some real motivation for rehabilitation, I would give consideration to subsequently suspending the sentence and placing him in an available program, if they could find a program suitable to his problem.

I soon received a letter from his wife, part of which read:

"I think my husband could still be a worthwhile person if given the help he needs with his drug problem. The only problem we ever had as far as our marriage goes stemmed from that. He has always treated me with respect and his children also. We have two children, a girl eight and a boy three. It is very hard to make them understand why their father cannot be with them. They love him and ask for him all the time, especially the little boy. The main problem came from the fact that he couldn't hold a job when he was on drugs. He had a very poor bringing up, but he can be as responsible as anyone else when he is not using drugs."

In a psychiatric evaluation report from the Department of Correctional Services, I was told the following:

"This is a 31-year-old married white man. He is incarcerated for having narcotics and paraphernalia in his possession and for forgery. He has a very long history of difficulty with the law, including truancy at the age of 13, breaking and entering, possession of narcotics, robbery, and forgery. His life style is definitely passive-dependent and he does not present a serious threat to other persons. He is a serious narcotic user and spends $15 to $25 a day for heroin. His work record is sporadic. A history of his past reveals a very laissez-faire relationship between himself and his father.

"Diagnostic impression: Severe sociopathic personality with heroin abuse. Recommendation: Routine processing through the prison system. Note: This man is quite unlikely to be a candidate for probation as his ability to manage on the outside is not likely to be any better than it has been in the last ten years."

The difficulty in this case is not really the decision, but rather what to do with the defendant. With that type of advice and recommendation, there is no alternative but to let him be processed through the prison system. The problem lies in the family he leaves on the outside. A further problem arises after he is processed routinely through the prison system. The maximum sentence he can receive for possession of narcotics is five years. There is very little hope that the five years in prison, if he spends that much time, is going to turn him out on the streets any better off than when he went in. Moreover, the chances are quite high that he will, when he does get out, resort to the same life style he had when he was incarcerated. So that really the prisons, in a case like this, are no more than revolving doors. A particular man is kept out of society temporarily, but neither his problem nor society's problem in respect to him are solved.

Case 2

Another case which I would like to mention concerned a 31-year-old Negro man who had been addicted to heroin since 1954. He was about 15 years old when he first came into court. He had been sent to the Lexington, Kentucky, Federal Hospital for Narcotics Addicts. He had also been sent to Spring Grove Hospital and had gone through their program. The people at Spring Grove were very enthusiastic about this individual, particularly because of his earnest motivation, and his high intelligence. They had hoped that he could make an adjustment. Before employment could be found for him, however, during his stay at Spring Grove, he was back on narcotics and was rearrested for larceny. He came before me on the charges that resulted from these crimes which he committed while he was a patient at Spring Grove Hospital.

I was convinced in the short time that I saw him in the courtroom, that he was a candidate for rehabilitation if some program could be found for him. He certainly presented evidence of motivation. He even admitted that he was tired of the drug habit. I knew that he had the ability to become a productive citizen.

However, he was guilty of several crimes and received a very substantial sentence, but was placed on probation. Presently, he is in Project ADAPT which is operated by Provident Hospital. It is reported that he is doing very well.

Overview

The real problem that the criminal courts have, from the drug abuse standpoint, is finding a program which will suit the needs of the addict. There are few programs available that offer any hope of helping a narcotic addict. Little is known about the effectiveness of these programs because the funds that are available to them are rather scarce and they are used for the programs themselves. Funds are not used in collecting statistics or follow-up.

While more knowledge about rehabilitation programs is becoming increasingly available than ever before, it is just a start. Much remains to be done and much remains to be noted. We have a long way to go before we achieve any real correlation between the criminal courts and rehabilitative programs.

The Addict, Rehabilitation, and the Law

STEVEN V. SKLAR, LLB
Delegate
General Assembly of Maryland
Fifth Legislative District
Baltimore

Drug abuse, and I speak mostly in relation to hard core narcotic addiction, is a primary cause of the increase in the crime rate today. We have estimates by statisticians and by judges in the Baltimore area, that 50%, if not more, of all crimes committed in the area are motivated by drug addicts in need of funds to support their habits.

Drug-Crime Cycle

Today we have what is known as a drug-crime cycle. As Judge Ross said, the addict who is hooked needs about $50 a day to support a modest habit. In order to get that, he has to resort to illegal means, ie, forgery, burglary, etc. Judge Ross quoted a figure that he has heard that is as high as $140 a day. I met a lady at the correctional institution for women at Jessup who was on a $600 a day habit. Now, this is net. That is what she basically needed. However, she needed close to $2,000 a day of stolen property just to keep her head above water.

The traditional approach to this cycle of drugs and the necessary crime to support the drug habit has been a characterization of the problem as criminal (It is a crime), and the approach has been penal (Put them in prison). Well, we don't think that that approach has worked very successfully.

Recently, the General Assembly passed and the Governor signed the Comprehensive Drug Abuse Control and Rehabilitation Act of 1969. What it does is this: It invokes a change of philosophy. Instead of combating the drug problem by merely drying up the availability of drugs and, therefore, the opportunity for addiction, we think that a new approach, a realistic approach, should be taken. Instead of viewing the addict as a criminal, we are viewing him as a medical problem. Instead of trying to rehabilitate him in an institution, we hope to offer him therapy in a medical setting.

New Approach Developed

Therefore, we have a new bill, House Bill 1257, which sets up a new approach in Maryland to combat the problem of drug abuse. Very briefly the act does this: It sets up a three-man authority called the Drug Abuse Authority, whose power is to regulate, devise, operate, and administer all of the drug programs in the state. The crux of the bill is a commitment proceeding. Under the proceeding, a man who is not charged with a crime, but who is an addict, may voluntarily petition the circuit court of the city or county and ask to be committed as an addict to the jurisdiction of the Drug Abuse Authority. Or else, someone close to him, who has a special interest as defined by law, may petition the court, saying that the person is an addict and should receive care. Persons who have been convicted of crimes in the circuit courts or in the lower courts, as an alternative to sentencing in a penal institution at the discretion of the trial judge, may be committed to the Drug Abuse Authority for rehabilitation programs. Even the prisoners already incarcerated may, under certain

circumstances, and with the approval of the State Parole Board, be committed by court order to the authority of the three-man commission, the Drug Abuse Authority.

It is also the duty of these three men, who are appointed by the Governor, to devise, coordinate, and conduct rehabilitation programs within the state.

Now, the law is purposely flexible. We do not, as legislators, want to define the best medical approach or the technique to be used. This is not our area of expertise. This area is left to the people who do have the expertise, the physicians and those in allied professions. What we are trying to do is to insure flexibility of approach. If methadone proves to be a very effective method of treatment, then we want it to be used. In fact, we have permissive language in the bill which calls for the use of maintenance dosages of addicting drugs. Under the law, methadone can be used under the auspices of the state. What we want to do now is to insure that any new developments that come out of the medical profession and medical research can be used in any subsequent state program for rehabilitation. We do not want to be limited to past programs that have outlived their value and effectiveness.

Under the act, the Drug Abuse Authority is empowered to conduct research in the state. It is also designed to educate and train physicians, nurses, and medical students in the area of drug addiction and rehabilitation, as well as to inform the public about the problem. The authority also has facilities available to gather and maintain needed records and statistics.

It is the duty of every physician in the state to report to the Drug Abuse Authority any information their regulations require in regard to drug abuse and the treatment of drug addicts.

Finally, the Drug Abuse Authority must approve and authorize all rehabilitation programs in the state, as well as approve every individual physician who offers treatment in the area of drug abuse. It is important that we have strong regulations in the area, because if there are poor standards in any program, especially one in which maintenance drugs are being used, there will be abuses in the program, and these abuses are going to produce two results. One will be ineffectiveness as far as any rehabilitation goes, and the other will most likely be illegal drug marketing.

Educating the Public

The legislature is concerned with a number of problems. First, we have to educate the public Presently, the public is insensitive to the plight of the addict. They hear about it, they read headlines about raids, prosecutions, and convictions, but they are insensitive to the man who is affected by the drug. What we have to do is to try to eliminate the traditional approach to drug addiction in the minds of the public. You just cannot take an addict, put him in jail, throw the key away, and hope for him to come out a rehabilitated individual and never resort to his habit again. We have to take a realistic and sensitive approach to the addict himself.

Operating Programs

Secondly, the concern of the legislature is to stimulate the medical profession to develop and to operate programs that are effective and reliable in the area of drug abuse. There are many gaps in our knowledge now on how to treat an addict. About the only point you will have agreement on is that there is a diversity of opinion in the medical circles. But there are new programs that appear promising, and that have produced results which are significant. I think we are now on the threshold of breakthroughs in the medical field.

We must discourage what I think is petty bickering and rivalry between the competing philosophies and approaches to drug abuse today. The medical profession, no less than any other group, is subject to political give and take. On one side you have an abstinence program, whose philosophy of drug abuse and drug addiction is psychological, and on the other hand you have the maintenance approach, whose treatment is predicated on a metabolic reason for drug addiction. But the problem is that you have very little acceptance by one school of the other's teachings, approaches, or results. In effect, you have an attempt to cover up shortcomings in a program, and to "fudge" results and statistics. Generally, a noncooperative attitude exists between the groups, and the ones who lose are the poor addicts that come in for treatment.

We, as legislators, must encourage the addicts themselves, through the law and through other means, to avail themselves of the opportunities for rehabilitation. We have to make programs. We have to make legal alternatives attractive enough so that an addict will come in on his own and seek help. Word of a program with proven effective results quickly spreads, and the addicts want to come.

Coordinating Policy

We must coordinate an effective policy toward drug abuse on all levels. This means the courts, the legal profession, the medical profession, the pharmacists, the social services, the police, and most importantly, our school system, must all work together.

We view drug abuse today as a threat to our safety, and to our continued prosperity. But we cannot waste our time on more studies. The time today is for action. If we have an enlightened approach and if we develop reliable, effective rehabilitation methods, then the government and the medical profession together, can make a real inroad to solving a previously unsolvable dilemma.

Methadone Maintenance Treatment Program

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Methadone Maintenance Treatment Program
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Drug addiction has reached epidemic proportions in New York city and in other sections of the United States as well. An effective treatment for severe heroin addicts known as the Methadone Maintenance Treatment Program has been developed at Rockefeller University and has continued in a greatly expanded program at the Beth Israel Medical Center in New York.

Facilities for the treatment of narcotic addiction were almost nonexistent in New York until the 1950's. It was then that the increase in the number of addicts in the low-income areas was recognized, as was the increase in the use of narcotics by the young. Concerned city authorities prompted the Department of Hospitals to establish facilities for adolescent drug users. As a result, a 140-bed hospital, Riverside Hospital, was opened in 1952. Psychiatrists and strong rehabilitative and supportive services were provided. In addition, beds were obtained in a proprietary hospital, Manhattan General Hospital, to detoxify narcotic patients. With one exception, the chiefs of service of the municipal general care hospitals resisted the treatment of drug addicts in their service. Few physicians were interested, and almost all refused to treat the addicts.

A study was done by Columbia University in the late 1950's of 248 patients discharged from Riverside Hospital. It showed that almost 100% of the patients still alive became readdicted shortly after discharge. Ray E. Trussell, MD, Director of the School of Public Health and Administrative Medicine of Columbia University, during a sabbatical leave, had been appointed Commissioner of Hospitals of New York city in 1961. Dr. Trussell, as a result of the Riverside Hospital study, and because of additional serious administrative problems, decided that Riverside Hospital should be closed, and that we should seek new approaches to treat drug addicts. Riverside Hospital was closed in 1963. Although it had given its patients some social assistance, it failed both in preventing readdiction and in rehabilitating its patients. It seemed clear that the answer to the treatment of narcotic addiction lay in new directions to be determined by future research.

Research Encouraged

The Health Research Council of New York city was interested in encouraging research in the area of drug addiction, and in 1963 they initiated a grant to two Rockefeller Institute physicians: Vincent Dole, MD, a specialist in metabolic research; and Marie E. Nyswander, MD, a psychiatrist with long experience in drug addiction.

Dr. Dole and Dr. Nyswander attempted to find a means of treating a patient which would enable the patient to function productively in society. The researchers considered drug addiction as a physiological disorder and thought it reasonable to ask whether some medication might control the drug hunger. At first, they attempted to maintain patients with morphine. While this did away with much of the patient's antisocial behavior, it did not make him productive. Next, they used methadone in an unusual way, giving their patients gradually increasing doses until the tolerance level was reached, usually between 80 to 120 mg daily. When patients reached this maintenance level, usually after six weeks of treatment, the physicians found that several things happened:

1) The patient showed no harmful effects from methadone. He was neither sleepy nor high. Medical examination and all types of medical, physiological, and psychological testing showed no harmful effects from methadone.

2) The patient lost his drug hunger.

3) The effect of heroin was blocked. Even when given an injection of heroin, the patient experienced no effects from it.

4) The dosage of methadone, once established, remained stable. It did not have to be increased, and was long-acting (24 to 36 hours).

Growth of the Methadone Program

After intensive study and experience with six patients, Dr. Dole went to Dr. Trussell, showed him the histories of his six patients, and asked for facilities to expand this work. In 1965, through Commissioner Trussell's efforts, beds were obtained at the Manhattan General Hospital. This hospital of 386 beds later was acquired and became an integral part of the Beth Israel Medical Center. This was done through the help and cooperation of the president of the Board of Trustees of the Beth Israel Medical Center, Mr. Charles H. Silver. In 1966, the center was renamed the Bernstein Institute of the Beth Israel Medical Center. It is the largest center for drug addiction under voluntary auspices. Methadone Maintenance is one of several narcotic programs of the Bernstein Institute.

In five years, the Methadone Program has expanded to the point where over 1,300 patients are currently being treated in four hospitals and 15 clinics under the sponsorship of the Beth Israel Medical Center. Several additional voluntary and municipal hospitals and clinics are now almost ready to join the Beth Israel Methadone Maintenance Treatment Program. The inpatient phases of the work are done either at Beth Israel or at Harlem Hospital. Clinics have been established at Beth Israel Medical Center, Harlem, St. Luke's, and Cumberland Hospitals. In addition, a number of hospitals in New York city have established their own methadone programs based on the work done previously at the Beth Israel Medical Center.

This program considers the addict a patient with a chronic disease. The individual whom it treats is the hard-core addict who suffers from euphoria and drug hunger, is unable to function socially or economically, and must take drugs to relieve his physical misery.

Naturally, we realize that it would be best if the cause could be removed and the patient made drug-free. But all programs which have attempted this in a community setting have failed. This program deals with the symptoms. The methadone blockade against opiates frees the addict from his drug hunger so that he becomes receptive to rehabilitation. It should be stressed that this program deals with the long-term, usually criminal addict, who has been unable to make it in any other way. Our goal is social rehabilitation for those who have been unable to achieve abstinence.

Treatment Approach

The Methadone Program is not based on a psychiatric approach. While psychiatric consultation is needed for a number of patients, it is not the primary modality. Our experience has shown that the program is equally effective in a department of psychiatry, medicine, or community medicine. The important factor is competent direction by an interested physician. Our experience has also shown that there should be available good medical and obstetrical services by physicians who are familiar with methadone patients and who are available for back-up in the program.

Intake of Patients

A central intake of patients for all the clinics and hospitals associated with this program has been established under the direction of a skilled staff. This staff has had experience working with addicts, and their backgrounds are essentially in social service. They screen the applicants for acceptability in the program. A research assistant (an addict in the program who has proven himself) is of great assistance in this procedure.

Originally, because this was an experimental program, very rigid qualifications for admission were established. These subsequent qualifications and their modifications are:

1. *Age*—Originally, age was set at 21 to 39 years. The patient had to be able to sign a consent form but could not be over 39 because of the theory that drug addiction decreases with age. The age requirement has now been changed to 18 years with proper consent. No maximum age limit now exists. We even treat patients collecting Social Security, and those registered with Medicare.

2. *Residence*—New York city residency is required because of reimbursement aspects.

3. *Addiction*—Only opiate addicts are accepted. Severe barbiturate and amphetamine users are rejected, as well as are those with multiple addiction (ie, combination of opiates with barbiturates). However, the final decision for acceptance may be modified by the clinician in charge.

4. *Length of drug use*—Originally, a minimum of five years of mainlining heroin was set. This has been gradually reduced and is now two years.

5. *Psychiatry*—Any history of psychoses or severe mental disturbance is usually cause for rejection. This may be modified by the clinician.

6. *Addiction in family unit*—If the patient's spouse is addicted, both must be eligible and admitted together. The same is true of any family members living in the same household.

7. *Alcoholism*—Severe chronic alcoholics are rejected.

8. *Mental deficiency*—Addicts are rejected if I Q is so low that they cannot handle the responsibilities of the program.

9. *Medical*—Cirrhosis of the liver, diabetes, epilepsy, and terminal conditions were originally reasons for rejection. We now have no medical exclusions.

10. *History of previous unsuccessful treatment*—This has now been modified, and a determination is made according to the judgment of intake personnel.

11. *Acceptance of patients*—Finally, the physician in charge must approve the selection of the patient.

Procedure

When it has been determined that the patient meets the criteria and a vacancy for treatment occurs, he is admitted into a *Phase I Program.* Originally, this was a six-week period of hospitalization on an open ward. This phase has been modified and now, in a high percentage of cases, it is done on a strictly ambulatory basis. The patient is given divided doses at first. As the dosage is increased, and there are no undesirable side effects, the dosage schedule is changed to a single daily dose. The methadone is dissolved in an orange juice substitute and taken orally.

After reaching maintenance level, the patient is next assigned to a *Phase II Clinic.* At first, the patient reports daily. He leaves a urine specimen which is tested for opiates (heroin and morphine), amphetamines, quinine, barbiturates, and methadone. He drinks his dose of methadone in front of the nurse, and periodically reports on his activities (eg, school, work), or problems. As the staff is convinced of the patient's progress, he is required to report less often—three times a week, twice a week, then once a week. However, when he does report, he drinks that day's dose of methadone in front of the nurse (to be sure that he is still taking it), leaves a urine specimen, and is given his daily supply of methadone for those days when he does not report to the clinic.

We try to limit the size of our Phase II Clinic to less than 100 patients. Each clinic has a part-time physician, a nurse or nurses (depending on the hours of the clinic), a supervisor, counsellors, a research assistant (ex-addict), and clerical personnel. Back-up medical, psychiatric, pharmaceutical, social, legal, and other services are provided when needed.

It is during Phase II that serious efforts are made in the rehabilitation of the patient. A wide spectrum of services is offered to the patient in the areas of medical care, counselling on problems of everyday life, social services in regard to family living and community resources, vocational rehabilitation, and legal defense advice. The older patients on the staff are especially helpful in this phase, and are constantly available to help with problems peculiar to addictive patients.

After a year, when the staff is convinced that the patient is doing well, at a job, at school or at keeping house, and the patient seems to have no problem with alcohol or drugs, he is assigned to a *Phase III Clinic.* The treatment is essentially the same, but the frequency of visits is much shorter and there is little need for the counselling staff. These services, however, are available if needed.

Evaluation

From the start, in 1964, this program has had independent evaluation of all the patients who have ever entered it. Originally, when the city financed this program, money was allocated to the Columbia School of Public Health to perform this evaluation. When financing of the Methadone Maintenance Treatment Program was assumed by the State Narcotic Addiction Control Commission in 1967, a separate contract was given by the state to the Columbia University School of Public Health and Administrative Medicine to continue this evaluation. A high-level committee was appointed. The charge to this committee was to evaluate the results of this program in an objective manner, and to make recommendations based on this evaluation. Frances Rowe Gearing, MD, was appointed the Director of the Evaluation Unit.

In their report of March 31, 1968, the committee reached these conclusions: "The results of this program continue to be most encouraging in this group of heroin addicts, who were admitted to the program on the basis of precise criteria. For those patients selected and treated as described, this program can be considered a success. It does appear that those who remain in the program have, on the whole, become productive members of society, in contrast to their previous experience and have, to a large extent, become self-supporting and demonstrate less and less anti-social behavior. It should be emphasized that these are volunteers, who are older than the average street addict and may be more highly motivated. Consequently, generalizations of the results of this program in this population to the general addict population probably are not justified. There remains a number of related research questions which need further investigation."

A report, as of March 31, 1969, showed there were 153 women and 861 men who had been under observation three months or longer.

> "Among the women, 10% were employed on admission. After 12 months, 33% were employed. Fourteen percent were homemakers, and 3% were in school. After 18 months, 65% were employed, in school, or homemakers and, after two years, this percentage had increased to 73%."
>
> "Among the men, the percent of those employed or in school increases from 26% on admission to 56% at 12 months, 70% at 24 months, and 83% at three years. The percent of men on welfare or supported by others decreases proportionately from 54% at six months to 44% at 12 months, 30% at 24 months, and 17% at 36 months."

"The arrest records of those who enter the Methadone Program and those who enter our Detoxification Program are similar. Patients who are accepted have to wait a long period. Acceptance into the program does not have a marked effect on their pattern of arrest in the 12 months prior to admission. Following admission, there is a marked decrease in arrests while the pattern of arrest among the contrast (detoxification) group is very similar to earlier patterns."

None of the patients who remained in the program have become readdicted to heroin. Problems with drug abuse (amphetamines and barbiturates) varied from 4% to 12%.

The Methadone Maintenance Treatment Program is an effective, economical way of treating hard-core heroin addicts who cannot be treated successfully with any existing programs. It can now be done on an entirely ambulatory basis for most patients. This makes the program feasible for those areas where inpatient beds are difficult to obtain. We feel it is very important that this program be a structured one so that it remains carefully controlled.

Methadone Maintenance Treatment for heroin addiction is a public health program. It should be accomplished under the direction of a public health department, a hospital, or an organized medical facility. Since rehabilitation and social productivity of the patient is the prime objective of this program, it is important that the means to do this must be an integral part of the program. It is not sufficient to prescribe methadone alone.

Under these circumstances, the addict is given a chance in a program which he is capable of handling, and which offers him a realistic path to living as a responsible member of his community and of society without the crutch of heroin.

Mr. Lichtman, whose statements follow, is a research assistant at the Beth Israel Medical Center. Before becoming an assistant there, he was a drug addict. In conjunction with Dr. Gollance's article on the Methadone Maintenance Program, Mr. Lichtman tells how the program has helped him.

I am 29 years old. I started using heroin at the age of 15. I used it for a period of approximately ten years. Approximately four of those years were served as a guest of the city, state, and federal governments in any number of institutions.

After a period of ten years, I found that a strange thing happened to me. I developed a certain motivation which I had not had during that time. I decided that I wanted something more than I had had for those ten years. I came to the Beth Israel Medical Center in April 1966, at which time I applied for the Methadone Maintenance Program. The reason that I had originally applied for that program is that I had unsuccessfully tried other methods of treatment when coming out of institutions in other programs. I found that the same drug craving which I had in going into a program would return upon my release from an institution.

I had heard many stories about methadone. I heard that while taking methadone you are still addicted, and you would not be able to function in the community. But I decided that since I had not been able to function in the other programs, that I would try methadone.

As I said, I went into the hospital, and stayed there for a period of six weeks, during which time the methadone level was increased.

After leaving the hospital, I returned to my family, who were skeptical. My father owns his own business in Manhattan. He is a furrier and does make a good living. During the ten years I was using drugs, he did not allow me into his place of business. When I returned there from the methadone program, as I said, he was skeptical, but was willing to take a chance with me.

I lived at home for four months, at which time I met a young lady who was also willing to take a chance with me and who knew my background. After about six months, we were married.

I now have a lovely home in Riverdale, and a new car. I work for the program in helping other addicts attain that which I have attained.

I find there is no real "hang-up" in using methadone. I leave a urine specimen when I come into the clinic weekly and pick up six bottles of medication to take home with me, which I take at my leisure. Methadone is a long-acting drug. I take the drug at any time during the day, and sometimes forget to take it and then overlap hours. The drug lasts anywhere from 24 to 36 hours. I have never experienced any withdrawal symptoms.

As I say, there is no drug craving, and no outward appearance of euphoria. Methadone does not produce these symptoms as other opiate drugs do.

In the time I have been on the methadone program, I find that there are many people who are willing to take a chance on the addict population once they (the addicts) are stable on it, ie, the maintenance drug. In New York city alone, we have many large organizations, such as the telephone company and large construction firms, who are willing to employ some of our people in the program.

It is difficult for me to tell you all of the things that have happened to me in the past. I have a new life today and it is something that I was never able to have before.

The Communication Gap and the Drug Problem

I am here to make a plea for communication—the kind of communication that should exist between patient and physician, between teacher and student, between parent and child, and between husband and wife, but does not. This lack of real open-door communication leads to drug use. In Canada, experts found, when they talked to young drug users, that the kids complained of having no one to identify with or to communicate with.

NEIL SOLOMON, MD, PHD
Secretary of Health and Mental Hygiene*

I would like to share with you an experience that I had recently in Canada with the leading officials there concerning the drug problem. Before doing so, I would like to ask the research assistant, Mr. Lichtman, to tell me why he started taking drugs.

Mr. Lichtman: There are a number of reasons why I started using drugs. I came from an upper middle income family, but I felt as though this was not what I was seeking. I just drifted off to a new group of friends who were not of the class that I was used to. I felt that this was a new thing. It was something that I could try that they had tried and said was wonderful. But I found that once I had become addicted to heroin, it was a lot easier to get started on it again than it was to get off of it. It was so easy to start. I just kept going to jail and other institutions, then coming out and returning to drugs because of these people whom I associated with.

Mr. Lichtman's is not an atypical explanation, and the thing that we learned is that if you have to pinpoint one specific reason, you cannot do it. Everyone is an individual and everyone has his own reasons for using drugs. But if you are looking for some basic, underlying, general reason, it is lack of communication. This is the lack of communication that is found between someone whom you trust, care about and identify with, but cannot communicate with.

The Canadian experts went into the field and talked to kids. These kids, drug users, complained that they did not have anyone to communicate with. "If we could have talked with our parents, really talked with them on a two-way basis, perhaps we would not have taken it (drugs), but we could not talk with them," one young person remarked.

I feel that the answer to the problem lies in education. And I do not just mean educating the student. I mean educating the community and the parents, in addition to the students.

Parents and children should be educated to react to each other in a way that does not seem frightening to children nor challenging to parents.

Let me be more specific. Suppose we organize a program, whereby one student from each school would be designated to meet with us in groups and discuss the problem, we could begin to solve the communication problem. We would meet with those students with positive attitudes, not those in trouble. We would try to get them to reach the troubled students by their own interaction with the other students of their schools. The majority of students want to do what is right and proper. But sometimes they are quite confused and their sense of values is "up for grabs". This is their vulnerable period.

Of course, I feel that if you cannot prevent the problem, you must cure it by rehabilitative means. There is no substitute for the dollar in developing rehabilitative programs throughout the state.

Many people ask, "Where are the drugs coming from? And what about the laws?" I believe that we should strengthen the laws, but direct them more towards the suppliers than the users. Take marijuana, for instance. The students are not going out looking for marijuana. They are not driven by a psychological and chemical addiction to get it and take it. The suppliers are coming to them. The students that we spoke with in Canada and the students that I have spoken to here will not go out and seek it. However, they will take it when the supplier comes to them.

If you could eliminate the suppliers, you would eliminate the problem. I feel that the problem of marijuana could be eliminated in this country if we could get to the suppliers, and there is no reason why we cannot do this.

I believe that the Mafia is involved in bringing the hard narcotics into this country and Canada. There is no question about it.

The Mafia sells marijuana to students for a reason. It really does not profit the organization, as such. But it involves the students with the hard stuff, the profitable stuff. It is not hard to slip something into the marijuana and get the students hooked.

Some kids, to whom the Mafia did this in Canada, noticed that after smoking marijuana, they experienced reactions which they had never had before. They were sick. They went to their local physicians, and were given an antidote for this type of drug. It was not the proper antidote. As a result, one person died, and several others came close to dying. There was no known antidote for this material because the material was not known.

This same group of marijuana smokers then went to the scientists at the University of Montreal. These men analyzed the material in the marijuana and found it to be an STP derivative. They also found out that the proper antidote was completely different than that which was given to the youngsters at the hospital. Naturally, they prescribed the correct antidote and notified the area physicians about the matter. When the youngsters realized that they had been double-crossed, they gave the authorities information about the pushers.

This proves that a person's sense of values is, at times, placed in a precarious position. If there is no way for a person to reinforce his positive qualities, this precarious position leads to drug use. It is our job to educate any would-be user to the inherent dangers in drugs. But education cannot take root without communication. Lack of communication began the drug problem and only adequate communication will end it.

** Maryland's Secretary of Health and Mental Hygiene, Neil Solomon, MD, PhD, while not listed in the program as a panel member, gave his views on drugs from the audience when called upon by Chairman Kolodner.*

Following Dr. Solomon's remarks, members of the audience supplied written questions to the Chairman of the panel, Dr. Kolodner.

A panel discussion followed and included Dr. Solomon, Dr. Gollance, Mr. Sklar, Judge Ross, and Mr. Lichtman.

Chairman: How long must methadone maintenance continue? Must it be continued for life?

Dr. Gollance: This is a question we have kicked around for a long time. It is a natural question to ask, "Can you take the addict off after time?" Under carefully controlled conditions, we have considered it. However, when we talk to our patients, as you heard Mr. Lichtman say, they will tell us, "Look, I have a job now for the first time, I have some money in the bank . . . don't let me down." One fellow said, "I drive a Volkswagen, I am married, I have a child. If I go off methadone and take a shot of heroin because I have a problem and I get arrested, everything I have accomplished in the last few years goes down the drain."

It is something that we would like to try very carefully if we had resources. At this point we are putting all of our dollars into the 80% of those patients that we know we can help.

Chairman: Will the delegate and the judge comment on the influence of organized crime such as the Mafia in this problem and whether proper attention is being given to this?

Mr. Sklar: First, the Mafia itself is concerned with certain aspects and certain types of drugs. Heroin is exclusively the domain of the Mafia, no one else. If anyone else gets into the market, they are very quickly eliminated. It is very easy to pull off a gangland murder in the narcotic area. Joe Smith is found dead one day from an overdose of drugs, and who is to say whether he administered it himself or someone else did?

All (if not almost all) heroin is imported into the country from France. It is originally grown as raw opium in Turkey and then smuggled into France where it is processed, particularly in Marseilles. The Mafia makes its purchases throughout France, smuggles it in through New York almost exclusively, and then has a very, very intricate and vast distribution system within the United States.

There is so much profit involved that anyone who wants to make a buck, who is in the Mafia, certainly does. One hundred kilograms of raw opium is converted into 10 kg of morphine raw base, which then goes to make 1 kg of heroin. When it was first purchased in Turkey illegally, it is about $3,650 for that 100 kilograms, and when it arrives on the street, or in any local hangout for narcotic pushers in the city, that same 1 kg of refined heroin that started off for $3,650 is retailed in the vicinity of $225,000.

So you can see that organized crime is really in it for the profits. They use the money from this to finance other aspects of illegal activity, numbers, legitimate enterprises, front enterprises, construction, etc.

It is very difficult to track these people down, and get back to the top in a multilevel distribution system, particularly when you have to produce evidence to convict in court. But the police are doing their best job. Seventy percent of all convictions of Mafia personnel in the country are on drug convictions. It is a slow process, but we can assure you the federal and state officials are doing their best.

Judge Ross: There is very little that I can add to the fine answer that Delegate Sklar has given.

Chairman: Dr. Gollance, maybe you can answer this: What is the cost overall each year for each addict?

Dr. Gollance: This has been dropping for us each year. Originally, when we had to have six weeks of inpatient hospitalization, it was expensive. At the current time, with all the supporting services we give—and this includes not only counselors, research assistants, pharmacists, and nurses but even a lawyer on a full-time basis to help patients clear up their legal difficulties so they can enter the program—it is now about $1,000 a year for each patient. But as we get more and more patients into phase three, it should decrease, and as we go on a greater ambulatory basis, the yearly cost should decrease.

Chairman: I will field this question: What is being done to prevent the development of addiction?

Mr. Lichtman: I think by stemming the tide of the active addicts within the communities you would greatly stem the possible addiction of further adolescents and youth. By taking the older addict out of the community and putting him into treatment, less drugs would be available to the young people.

Dr. Solomon: I believe that the educational aspects should be controlled on a local level, with the help, though, of state and federal experts. But I would leave it up to the local people to decide what their problem is. Then help them to educate the people in their area to deal with this problem.

Chairman: Would Dr. Gollance please discuss the treatment of addicts in the private physician's office with methadone?

Dr. Gollance: We are opposed to this. We feel that methadone should be only used in a very structured program. As I said earlier, the methadone just permits you to begin to work with the patient. It is not just the giving of the methadone.

We had one physician from Florida who had started to do this on his own. By our standards, he was doing everything wrong. When he came up and saw what we were doing, he agreed to close his clinic. I read later in one of the Miami papers that the Federal Bureau of Narcotics had taken away his narcotic license.

Chairman: How can the Women's Auxiliary to the Medical Society help in this program?

Dr. Solomon: I think that if this society can give the youth of today straight, honest answers, our young people would decide not to take drugs.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on Thursday, October 8, 1970, and took the following actions:

1. Authorized legal counsel to proceed with injunctive action against the use of the term "Chiropractic Physician", after consulting with the Attorney General;
2. Authorized proceeding with a Survey on Professional Liability incidence in Maryland for the past ten years, and appropriated funds for this purpose;
3. Agreed that physicians' defense panels should be held at various locations in the state rather than only in Baltimore, but that variations would occur depending on the defendant's and the panel participants' location;
4. Agreed that legal counsel should not reveal to defendants any written communications in cases that are discussed within the physicians' defense panels;
5. Agreed to recommend that the Commissioner of Motor Vehicles appoint Mario Mendoza, MD, Silver Spring, to the Medical Advisory Board;
6. Declined to appropriate funds for a general mailing by the Nursing Home Liaison Subcommittee inviting members to a meeting to discuss Responsibilities of a Medical Director of Nursing Homes, Extended Care Facilities, etc. It suggested that such a notice could be included in another general mailing and the date coordinated to accomplish this objective;
7. Authorized an expenditure of up to $200, if needed, to finance the Fourth Annual Seminar on the Medical Aspects of Sports;
8. Adopted Responsibilities of a Medical Director of Nursing Homes, Extended Care Facilities, etc., as recommended by the Subcommittee on Nursing Home Liaison;
9. Recognized the retirement of Ellen D. Gordon, who has been with the Faculty for 35 years.



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Genetic and Environmental Determinants of Chronic Obstructive Pulmonary Disease

Prevalence of abnormalities of pulmonary function among 156 relatives of 61 patients with chronic obstructive lung disease was found to be significantly higher than among 86 controls. Pulmonary impairment was more severe among smokers.

Recent reports have emphasized the association between a marked deficiency of a serum glycoprotein, alpha$_1$ antitrypsin, and chronic obstructive pulmonary disease. Since this protein deficiency is genetically determined, the question arises whether it accounts for all familial emphysema.

The present study was undertaken to investigate the prevalence of obstructive pulmonary disease and its relationship to alpha$_1$-antitrypsin deficiency among relatives of patients with chronic obstructive pulmonary disease. In addition, a group of spouses of these relatives was studied to provide a control group.

In all, 203 persons were studied, including 61 patients—designated in this study as index cases—156 first-degree relatives (siblings, parent, son, daughter), and 86 spouses of these relatives. All were at least 21 years old and lived within a 100-mile radius of each other.

Prevalence of Disease

Approximately 23% of the relatives were found to have obstructive pulmonary disease as compared with 9% of the controls.

Severe abnormalities were seven times more prevalent in the relatives than in the controls (8% to 1%). However, since the numbers were small, the level of statistical significance was just 5% (chi square).

Of the 61 family fragments in this study, 22 families had at least one person other than the index case who was found to have chronic pulmonary disease. Twelve families had one other afflicted relative; eight families had two; one family had three, and another family had five.

There were a total of 58 afflicted family members, including the 22 index cases.

Antitrypsin Levels

Alpha$_1$-antitrypsin levels were measured in 41 of these afflicted subjects according to the method described by Briscoe and associates. The only deviation from this method was that the optical density was read at 410 after the reaction was stopped with 0.1 N hydrochloric acid.

Serum level of alpha$_1$-antitrypsin activity has been used to identify persons with severe deficiency of the glycoprotein (homozygotes) that results from two defective genes, or persons with a lesser, or intermediate deficiency (heterozygotes) that results from a single defective gene.

In the homozygous genotype, the antitryptic level is very low (0 to 400μ/100 ml serum). In heterozygous genotypes it is usually between 401 to 900μ/100 ml.

In all 41 of those tested, alpha$_1$-antitrypsin levels exceeded the maximum homozygous level. In only

Roger K. Larson, MD, Martin L. Barman, MD, Friedrich Kueppers, MD, and H. Hugh Fudenberg, MD.
Annals of Internal Medicine, *May 1970 (Vol. 72, No. 5).*

two subjects did it fall within the heterozygous range.

Furthermore, only 10% of 91 relatives tested fell within the heterozygous range while 16% of 70 controls did.

Even more surprising, perhaps, is the fact that only 7% of 96 patients with mild to severe chronic obstructive pulmonary disease tested (9% of 67 with severe disease) fell within the heterozygous range while 15% of 118 normal subjects did.

Role of Heredity

The possibility that emphysema may be the result of hereditary factors was suggested as long ago as 1845. The present study gives further support to this concept.

In this study, however, abnormal relatives were found in only 22 of the 61 family fragments. Moreover, two thirds of the abnormals were found in just ten family fragments. From this data it is not possible to conclude that all chronic obstructive pulmonary disease is genetically determined.

At first glance the study would appear to suggest that heredity plays a more prominent role in women. A much higher percentage of abnormalities was found among smoking female relatives (29%) than the controls (0%). Such a disparity was not detected between smoking male relatives and controls. The percentage of smoking male relatives with abnormal pulmonary findings (25%) was close to the percentage for the smoking male controls (22%).

However, on closer scrutiny, 18% of male smoker relatives were classified as severe as compared with 3% for the comparable controls (significant at the 5% level). Thus, the relatively equal prevalence is somewhat specious and tends to mask the marked qualitative difference in severity.

The single-gene abnormality of alpha$_1$-antitrypsin deficiency has been reported to be associated with a very high prevalence of chronic obstructive pulmonary disease. This curious association was discovered by serendipity and has not been adequately explained as yet, although some hypotheses have been proposed in the literature. The present study suggests that familial chronic pulmonary disease may occur with or without alpha$_1$-antitrypsin deficiency and that the latter is less common.

In view of recent studies, however, showing an elevation of alpha$_1$-antitrypsin levels in heterozygotes into the normal range in the presence of infection, it is possible that some heterozygotes could have been missed in the present study. Additional studies will be necessary to clarify this point.

Although an attempt was made to subclassify the index cases and abnormal relatives as to type of disease, it became readily apparent that the vast majority fell into the broad category of the bronchitis-emphysema syndrome. Onset of disease with accompanying dyspnea occurred early in life for many. Furthermore, family histories of the afflicted patients revealed that females were affected as commonly as males.

Role of Smoking

Although an analysis of the effects of smoking on pulmonary function was not the primary purpose of this study, it was apparent that smoking was significantly associated with functional abnormalities. The prevalence of abnormality was lowest (3%) in nonsmoking controls. The prevalence was highest in the 107 relatives who smoked (27%). Similar patterns, falling between the two extremes, were detected in nonsmoking relatives and smoking controls.

Thus, it appears that heredity and the environmental factor of smoking may be co-determinants, with each contributing equally to the likelihood of the development of chronic obstructive pulmonary disease.

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At the recent American Association of Medical Assistants' National Convention, Maryland was represented by the following members:

Delegates: Dorothy Hartel, Baltimore Chapter
Jean Subock, Baltimore Chapter
Pat Carter, Allegany Chapter

Alternates: Pat Muenster, Wicomico Chapter
Mabel Young, Allegany Chapter
Gertrude Gillum, Allegany Chapter

Gertrude Gillum also served as a page at the House of Delegates meeting. The convention was held on October 28-November 1, 1970.

* * *

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* * *

The members of the association are grateful to Henry L. Wollenweber, MD, who has served as advisor to Baltimore city for the past four years. He has been most helpful to all Maryland Assistants, especially with his enthusiasm and help in the educational programs sponsored by the association.

Dr. Wollenweber



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Baltimore City Medical Society

Board of Directors Meets

The Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral Street at 4:35 PM on August 11, 1970. The meeting was called to order by the President, John N. Classen, MD. Present at this meeting were: Drs. Classen, F. K. Adams, E. F. Cotter, J. E. Levi, R. L. London, P. F. Wagley, and R. E. Farber. The minutes of the June 2, 1970 meeting were approved as distributed.

The first item on the agenda was a discussion of the Peer Review Committee for the Baltimore City Medical Society. Dr. Classen stated that he was still trying to find the right person to be chairman of this committee and asked for further suggestions.

Since the Board of Medical Examiners intends to use the national *FLEX* examinations beginning this December, the meeting hall of the Medical and Chirurgical Faculty building will be furnished with desk chairs. This will necessitate the use of these seats for the December meeting since adequate time for replacement of the usual furniture will not be available.

The Board of Directors then discussed the recent salmonella outbreak at Gould Convalesarium. Dr. Farber stated that the concern was the seeming delay in reporting the epidemic to the health department and expressed hope that something could be done to urge physicians and nursing homes to practice better reporting procedures. Neil Solomon, MD, PhD, has written a letter to Dr. Farber instructing him to turn over all information concerning this matter to the Medical and Chirurgical Faculty for investigation. A committee has been set up by Med-Chi for this purpose. There was some discussion about this procedure and it was the consensus of the Board that since the nursing home was in the city, an investigation should properly be carried out by the Professional Relations Committee of the City Society.

A suggestion was made that a resolution be formulated and presented to the Med-Chi House of Delegates suggesting to the Governor that prior to making appointments which concern the health of the people in the State of Maryland, consultation should be held with the medical profession. They could then submit a list of candidates qualified for the position.

Dr. Levi stated that he felt that if there were any wrongdoing on the part of the physicians at the nursing home it should be investigated by the City Society and proper action taken. But he warned that the Society also had the responsibility of protecting the physicians and should not allow them to become "scapegoats" if innocent. Since Dr. Classen plans to meet with John Schaefer, MD, who is chairman of the Ad Hoc Committee set up by Med-Chi to investigate the matter, it was suggested that he bring this subject up for discussion at the future meetings of the Medical and Chirurgical Faculty.

The Board voted to request the Medical and Chirurgical Faculty to grant Emeritus Membership to Robert B. Mitchell, MD.

Next, the composition of the Regional Planning Council was discussed. Dr. Farber informed those present that the law requires that 51% of the membership of the Council be made up of consumers. This leaves few places for professionals. There are numerous committees which advise the Planning Council. The Society is represented on two of these by Frank Kaltreider, MD, and Harry F. Klinefelter, MD. Dr. Farber suggested that if there were any specific items which the Society would be interested in having clarified or discussed, William Hiscock, Director of Health Planning for the Regional Planning Council, should be contacted.

Further correspondence about the Maryland Artificial Kidney Treatment Fund was reported by Dr. Wagley who stated that a letter had been received by Gordon Walker, MD, from the husband of a former patient under this program. As soon as Dr. Walker returns from vacation, this matter will be considered further.

The next item on the agenda was a report from

the Committee to Develop Standard Physical Examination Forms for Campers. A report was submitted from this committee suggesting the use of the *Supplemental Form Health Memorandum for School and Camp*, printed by the Academy of Pediatrics. It was felt, however, that this matter of form revision did not solve the problem, since many children in the inner city do not have a physician or any means of having the form completed. It was agreed that a letter be written to Conrad Acton, MD, chairman of the Boy Scout Committee, requesting the committee to investigate the possibility of having members of the Society volunteer to provide physical examinations to indigent children prior to attending camp.

A discussion of a newsletter printed by the "People's Free Medical Clinic" followed. Dr. Wagley suggested that C. Lee Randol, MD, be contacted regarding several statements in this newsletter which the Board felt were disparaging to present social order and to the medical profession.

The final item on the agenda was a report concerning the MUND project. Apparently the MUND project has run into difficulty in obtaining funds for planning from the Office of Economic Opportunity. No final decision has been made as to whether or not funds will be forthcoming from the federal government and, therefore, no action can be taken on this project at the present time.

The meeting was adjourned at 6:45 PM.

The Board of Directors of the Baltimore City Medical Society met on September 8, 1970 at 4:30 PM at 1211 Cathedral Street. The meeting was called to order by John N. Classen, MD, president. Those members present were: Drs. J. N. Classen, J. T. Chissell, A. E. Cocco, E. F. Cotter, R. B. Goldstein, J. R. Karns, W. K. Mansfield, P. F. Wagley and R. E. Farber. The minutes of the August 11, 1970 meeting were approved as distributed. A list of present committee members and vacant offices in Med-Chi and BCMS for 1971 was distributed to members of the Board, Delegates, and alternates, with the request that suggestions for committee appointments and nominations for the forthcoming year be submitted.

The first item on the agenda was related to the Maryland Artificial Kidney Treatment Fund. Dr. Wagley reported that a letter had been received from the husband of a former patient of the responsible physician but that nothing in the letter could be considered as evidence of unethical or illegal procedures on the part of the physician. Dr. Walker has informed him that there are several other letters in the process of being distributed but the committee has not met again to consider these.

The Board of Directors met with the Delegates of the Baltimore City Medical Society who were to attend the semiannual meeting of the Board of Delegates of the Maryland and Chirurgical Faculty. The Board recommended that the Delegates support Resolution 2S/70 which calls for the Professional Medical Services of Med-Chi to gather and maintain current information concerning the usual and customary fees of physicians, and also suggested that information concerning the relative cost of treating patients be maintained.

The Board felt that the intent of Resolution 3S/70 was unclear and agreed with the recommendation of the Reference Committee that this be referred to the Med-Chi Legislative Committee for consideration and investigation.

The third matter discussed with the Delegates concerned the report of a special committee set up to consider the value of continuation of the MEDIC NETWORK. The committee submitted the recommendation that the Network be continued and that each active member of Med-Chi be assessed $5 each year for the purpose of financing MEDIC and other educational ventures. After some discussion, it was agreed to favor this recommendation even though the network is not used extensively by city physicians. It was also suggested that means be explored for generating more interest in the programs which are considered excellent in quality.

The next item on the agenda was the discussion of the scholarship fund. Dr. Classen stated that Read's Drug Company has offered to donate a sum of money to the Baltimore City Medical Society Scholarship Fund if such a fund is approved by the Society. In order to get this money, the Society would be expected to acknowledge its receipt to the physicians to whom Read's usually sends presents at Christmas. Several persons present felt that a letter to physicians informing them of a donation from Read's might be interpreted as an endorsement of Read's Drug Stores. Dr. Wagley pointed out that since the Society has not voted on the scholarship proposal yet, Nelson Warfield of Read's should be informed that money could not be accepted at this time for that specific purpose. It was agreed that Mr. Warfield would be contacted for more definite information as to the amount of money involved and exactly how he wished the acknowledgements sent.

Dr. Goldstein read the following proposed amendments to the BCMS Bylaws to be presented at the October 1970 meeting.

AMENDMENT 1

Amend Article IX, after Section 6, by inserting the following new Section 7 (the remaining section being automatically renumbered):

CAPS PORTION TO BE ADDED

SECTION 7. A FINANCE COMMITTEE SHALL BE COMPOSED OF THE TREASURER AND THREE MEMBERS, ONE OF WHOM SHALL BE APPOINTED ANNUALLY BY THE PRESIDENT FROM THE CURRENT MEMBERS OF THE BOARD OF DIRECTORS FOR A THREE YEAR TERM. IT

SHALL BE THE DUTY OF THIS COMMITTEE TO MEET DURING THE FIRST WEEK OF JANUARY AND AT SUCH OTHER TIMES AS SEEM REQUIRED, TO FRAME RECOMMENDATIONS FOR ACTION BY THE BOARD OF DIRECTORS AS TO THE DISPOSITION, BY INVESTMENT OR OTHERWISE, OF ANY ACCUMULATED EXCESS OF INCOME OVER EXPENDITURES.

AMENDMENT 2

Amend Article V, Section 1.

CAPS PORTION TO BE ADDED

New Provision

Section 1. The officers of the Society shall be a president, a president-elect, a vice-president, a secretary, a treasurer, and six directors. These officers shall perform the duties prescribed by these Bylaws and the parliamentary authority of the Society. IT SHALL BE EXPECTED THAT THESE OFFICERS, AND THE DELEGATES AND ALTERNATES TO THE HOUSE OF DELEGATES OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND, WILL INCLUDE IN THE RESPONSIBILITIES OF THEIR OFFICE **ATTENDANCE AT ALL MEETINGS** OF THE SOCIETY.

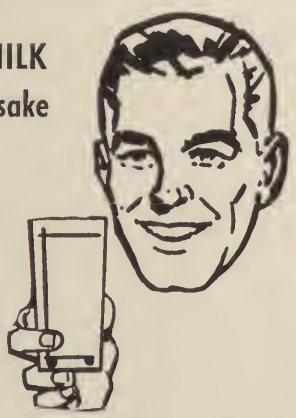
Dr. Classen urged the Delegates and alternates to make every effort to attend the meetings of the Society so that a true representation of the Society could be present when important issues are presented and voted upon. The delegates and alternates were then thanked for attending and the Board resumed its regular meeting.

The Med-Chi Liaison Committee has written to each component requesting that the matter of physicians signing out and leaving a recorded message telling patients to go to hospital emergency rooms for treatment be considered. There were several questions as to whether or not this was abandonment of a patient. It was agreed to ask the Liaison Committee for a ruling from the Faculty attorney as to the legalities involved and to contact Carroll County Medical Society and Wicomico County Medical Society for information as to how they have handled the problem in their community.

The last item on the agenda was consideration of a Peer Review Committee for the Baltimore City Medical Society. Katherine Borkovich, MD, has been requested by the Board to chair the Baltimore City Medical Society Peer Review Committee but as of this meeting she had not responded to this request. Dr. Cocco stated that the task of Peer Review throughout the state would require that the component societies formulate active Peer Review Committees. It is possible that Baltimore city may need more than one such committee. These matters were discussed at a meeting of the Med-Chi Peer Review Committee on September 9.

The meeting was adjourned at 6:20 PM.

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A highly purified concentrate of antihemophilic factor (AHF), for the prevention or control of bleeding episodes in victims of hemophilia, has been developed by the American Red Cross under a research contract awarded by the National Blood Resource Program of the National Heart Institute.

The new concentrate contains some 40 to 100 times as much AHF as does an equal volume of whole blood or plasma. It promises to be a major advance in the medical management of hemophilia A, by far the most common of the hereditary bleeding diseases that, in the aggregate, afflict an estimated 100,000 Americans.

The concentrate is prepared from blood plasma by a polyethylene glycol precipitation technique developed by Alan Johnson, of the American Red Cross Laboratory at New York Medical Center, New York. The technique is relatively simple and is suitable for extracting the AHF from large batches of plasma. The AHF free plasma can subsequently be processed to yield albumin, gamma globulin, and other plasma proteins for important uses in research and clinical medicine.

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Family Doctor Making More—Working More

A new survey shows that U.S. family physicians have increased their income since Medicare and Medicaid began in 1966, but only by slightly over 25% for the highest percentage-of-increase group. At the same time, this group, working an average of 59 hours a week in 1965, increased the number of hours worked a week by 15% and the number of patient visits by the same percentage.

The survey results reflect income and related practice data of 1,000 members of the American Academy of General Practice, the national association of family physicians. Respondents represent a random cross-section of the United States. They were requested not to sign the survey forms or give any identifying information, and advised that no attempt would be made to monitor postmarks or relate responses to the mailing list in any way.

The purpose of the survey was to find out how much family physicians had benefited financially from the two big federal health programs. A recent national publication had suggested there had been increases in earnings of as high as 71% since Medicare. This survey does show a rise in net earnings in all groups (categorized by hours worked per week). These percentage increases range from 5.3% for physicians working 41 to 45 hours a week, to 26.3% for the highest group in terms of percentage increase—physicians who work 66 to 70 hours a week.

Significantly, the survey shows that while number of hours worked a week and number of patient visits a week have gone up considerably for many of these physicians, the time spent for each patient visit has remained about the same. For example, the number of patients seen an hour is three and a fraction in all categories now, and was just about the same in 1965. This data indicates approximately 18 minutes for each patient visit in all categories.

The most significant general conclusion from the survey would appear to be that the more a physician works, the more he can earn, but not in direct ratio to additional hours worked.

This is illustrated by the net increase in earnings per patient visit since 1965. For all physicians working between 41 and 65 hours a week, this increase is stabilized at an average of about 44 cents. It drops off sharply to 30 cents in the 66 to 70 hour-per-week group, and plummets to a 14 cent increase per patient visit for the more than 70 hour-per-week group.

American Academy of General Practice



The Effectiveness of Vocational Evaluation in the Rehabilitation Process

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Vocational Evaluation was conceived at the Department of Rehabilitation Medicine of Sinai Hospital, Baltimore, on January 13, 1969, in conjunction with, and in addition to, the existing rehabilitation team (medical, social, psychological, speech and hearing, physical therapy and occupational therapy). The philosophy of the Vocational Evaluation program was that the patient-client would be given the primary responsibility in the exploration of new vocational areas. The client would then be the active participant having available to him the total rehabilitation team in case of physical, medical, psychological, or social barriers to the completion of the vocational process.

The Vocational Evaluation program has three plateaus. The first week of the program includes group psychological testing. The emphasis is placed on nonverbal tests, with the knowledge and understanding that all tests have limitations beyond the norm with a disabled population. No predictions are made directly from the tests. The tests are used as guidelines in selecting work-sample areas. The client's expressed interests are another primary factor in planning an individualized program of vocational exploration for each participant.

The second plane of Vocational Evaluation involves the exploration of appropriate work-sample areas. The TOWER system of work-samples published by the *Institute for the Crippled and Disabled* is the bulwark of this area. Other work-samples have been developed at Sinai Hospital and by Julian Nadolsky when he was the vocational evaluation director at the Baltimore League for Crippled Children and Adults.

Appropriate tryouts in hospital work areas represent the third level of Vocational Evaluation. The advantage of having a vocational program within a hospital complex is that a multitude of work areas exist (ie, laundry room, kitchen, print shop, store room, accounting department, central supply, and reception desks).

During the total process, major emphasis is placed on psychological variables. The client's self-concept and his attitude toward the requirements of work are evaluated. It is the belief of the authors that vocational success is dependent upon more than skill and intelligence.

For less than $30 thousand, 14 clients have been guided into competitive placement, two into sheltered employment, and 16 more are receiving additional

services before placement. More than 80 additional clients have completed the program and are included in the cost, but they have not been out of evaluation long enough to be considered in the follow-up data. However, the cost versus the productivity of this program is impressive.

The cooperation and support of the counselors of the Division of Vocational Rehabilitation of the State of Maryland has been important in the success of the program. The advice and guidance of John C. Kelly, liaison counselor of the Division at Sinai Hospital has, in particular, been most valuable.

Progress Report on Vocational Evaluation—January 1969 to December 1969

	Number of clients	Percentage of total
1. Handicap served		
Intellectual disabilities	18	16%
Physical disabilities	58	53%
Psychological and psychiatric disabilities	34	31%
TOTAL	110	100%
2. Referral service		
Baltimore city	75	68%
Baltimore County	31	28%
Outside metropolitan area	4	4%
TOTAL	110	100%

	Not followed	Followed	Successful	Unsuccessful
3. Disposition of recommendations				
Direct job placement	1	6	6	
Vocational training	1	5	3	
Continued education	1	2		
Workshop	7	5	2	1
On-the-job training	1	3	2	
Personal adjustment training	2	4	2	1
Psychological and psychiatric services	1	3		
Volunteer work		2		
Vocationally infeasible		3		
Work-study program		1	1	
TOTAL	14	34	16	2

Analysis of Program

A client must have completed Vocational Evaluation six months prior to follow-up. Vocational success is considered when a client has been employed successfully for a period of three months in a recommended or related area.

Forty-eight clients were eligible for follow-up as of December 1, 1969. Seventy-one percent (34) of the recommendations were followed.

Of the recommendations followed, conclusions can be drawn for 18 clients. Eighty-nine percent (16) of the clients are successfully employed in competitive or sheltered industry.

Summary of an Interesting Case

A 17-year-old man with an amputation below his right elbow, resulting from a farming accident, was referred for Vocational Evaluation in March 1969. He had been unable to function in school because he was ridiculed by his peer group about his prosthesis. He subsequently dropped out of school and refused to use his prosthesis.

During the evaluation process, it became obvious to this young man that he could become a much more productive worker by using his prosthesis. Therefore, he consented to wear it and learn to increase his competency in using it. Training was provided by a team occupational therapist with specialized training in upper extremity prosthetics. Because of this team approach, he was able to function adequately in the carpentry, machinery operation and electronics areas.

He was also given an on-the-job tryout with the hospital ground crew. Because of his rural farming background, he preferred this outdoor environment.

The rehabilitation counselor creatively combined these recommendations and placed the client as an outdoor carpenter's apprentice. For seven months, he has been working at this job earning $2.58 an hour. He is now a married man independently supporting himself and his wife.

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Geriatric Evaluation Service Progress

In its first full year of operation, the City Health Department's Geriatric Service has amply demonstrated its value and need in the Baltimore community. From a total of 131 elderly persons age 65 or over for whom mental hospitalization was in the offing, some 93 of them, or 70%, were aided by the project and were able to continue in the community, either at home, or in general medical or other facilities.

According to Mrs. Mary Guth, project director, 51 elderly persons were given help through community resources so that they could be maintained at home. This followed a medical, psychiatric, and social evaluation, which every accepted referral undergoes.

Thirty other elderly people were admitted to nursing homes, and another four, who were considered management problems, were continued at the nursing homes. Six were admitted to general hospitals for medical reasons, including one admission to a psychiatric unit. Two persons were accepted at boarding homes.

Only 38 patients (or 29% of the total number of patients evaluated) had to be admitted to mental hospitals. Of these, 33 were admitted to state mental hospitals and five were admitted to private psychiatric hospitals.

Fifty-eight persons who did not meet the criteria for the geriatric service were provided with information and referral according to their needs.

Another evidence of community need, according to Mrs. Guth, is indicated by a change in the source of referral. When the project was initiated, referrals came only from the preadmission services of state mental hospitals. In recent months, as the project's services became better known, referrals were increasingly made by private physicians or other individuals, or by community agencies. The Geriatric Evaluation Service now processes about equal numbers of referrals from the mental hospitals and from the community.

The Geriatric Evaluation Service has a budget for the current fiscal year of $64,717, from funds received on an approximately 50-50 matching basis through Title III of the Older Americans Act and a Community Mental Health Demonstration Grant of the Maryland State Department of Mental Hygiene.

The city's successful pilot program suggests to city and state health administrators the need for a state policy and appropriate funding for mandatory evaluation of all geriatric patients for whom mental hospital admission is pending, a proposal now under consideration by the Secretary of Health and Mental Hygiene. However, the needs of the elderly are many and complex and the aging process further complicates their care. An effective geriatric service should not only evaluate the elderly person's social, physical, psychological, and financial problems, but be able to ameliorate them so that the aged member of our community can continue to function in society. Mrs. Guth and her small staff of two part-time professionals and a full-time secretary, with the help of many individuals and community agencies, have shown that it can be done.

The Geriatric Evaluation Service is located at the Good Samaritan Hospital. The staff includes Mrs. Guth, who doubles as a psychiatric social worker and is involved in direct services to patients; Miriam S. Van Gelder, MD, formerly Chief of the Bureau of Special Health Services, Medical Care, in the State Department of Health; Mrs. Pansy K. Schmidt, psychiatric social worker, formerly with the city's Psychiatric Day Center; and Mrs. Judy Nawrozki, secretary. Joy Joffe, MD, internist, psychiatrist, and specialist in geriatrics, serves as a consultant. Three new positions which have yet to be filled have been included in the new budget effective September 1. These are two full-time psychiatric social workers, one of whom may be a public health nurse preferably with psychiatric experience, and a part-time psychiatrist or other physician with an interest in geriatrics.

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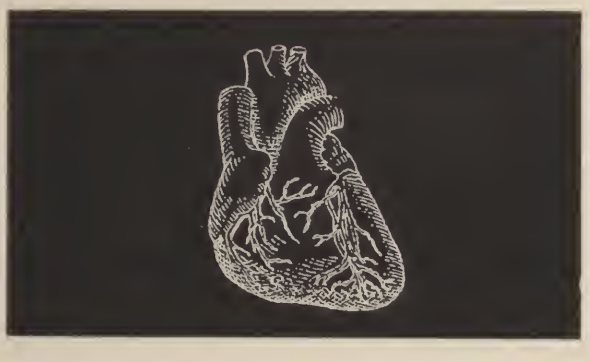
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MIRIAM L. COHEN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Treatment of Hyperlipidemia

SIMEON MARGOLIS, MD
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Baltimore

The aim in the treatment of hyperlipidemia is the reduction of serum lipid levels in order to prevent premature vascular disease in Types II, III, and IV and acute pancreatitis in Types I, IV, and V. The problems in management include the determination of which patients require therapy and the choice of diet and drug measures.

Three factors are of prime importance in the selection of patients for therapeutic efforts to prevent coronary heart disease. The decision is based not only upon the degree of hyperlipidemia, but also upon the age of the patient and the presence or absence of other "risk factors". The younger the patient, the lower the threshold for the institution of treatment, because in young subjects: (1) the association is stronger between hyperlipidemia and coronary heart disease; (2) therapeutic measures more often lower lipid levels; and (3) reduction of serum cholesterol is more effective in preventing new cardiac events. In contrast, there is no evidence that control of serum lipids benefits patients older than 60.

Thus, when severe hyperlipidemia is present, treatment is advocated for all patients less than 60 years old. When modest elevations of serum lipids are found, however, no hard and fast rules can be given for the selection of patients for treatment. All children and young adults with elevated serum lipids should be treated, especially if there is a family history of hyperlipidemia or early coronary heart disease. In fact, it is reasonable to institute dietary restrictions, at least, in young subjects with such a family history (and perhaps those with significant hypertension) even if their serum cholesterol falls within the normal range for our population. This course of action can be justified by several studies which indicate that, even at relatively low cholesterol levels, the risk of coronary heart disease rises as the serum cholesterol concentration increases. In older patients, treatment is advised in the presence of more severe lipidemia, or when other "risk factors" are prominent or overt coronary heart disease is present.

Detection of secondary hyperlipidemia is essential, since therapy is directed against the underlying disease state in these patients. Accurate typing of the primary hyperlipidemias is important because proper treatment varies with the type of lipid abnormality. Accordingly, specific therapeutic measures will be considered separately for each type of hyperlipidemia. In all hyperlipidemic patients, however, dietary management is the keystone of therapy. Drugs are employed, usually in combination with dietary measures, only when the diet is not sufficiently effective alone or cannot be followed by the patient. A handbook for physicians, entitled *The Dietary Management of Hyperlipoproteinemia,* is available on request from the Office of Heart Information, National Institutes of Health, Bethesda, Md.

It is difficult to predict the effectiveness of dietary or pharmacologic agents in any given patient. Therapeutic measures usually succeed within six to eight weeks or not at all. If dietary measures fail over such a time period, patients should be given a spe-

cific drug for about two months. If serum lipids do not fall, the initial drug should be discontinued and another tried in a similar manner. Reduction in serum cholesterol may be achieved in some patients only through the combined use of several drugs and dietary measures. Since patients should not be maintained for a protracted period on an ineffective drug or combination of drugs, there is a clear need for adequate baseline lipid values before institution of therapy.

Type I: Patients with Type I disease have exhibited no increased risk of premature vascular disease, but they suffer from recurrent bouts of abdominal pain, probably due to pancreatitis. The goal of therapy, then, is to reduce dietary fat sufficiently to prevent episodes of abdominal pain. This can be accomplished by restricting fat intake to about 30 gm daily. The diet can be made more palatable by the addition of triglycerides which contain medium-chain length fatty acids. Except for avoidance of alcohol, there are no other restrictions in these patients. To date, pharmacologic agents have not reduced serum triglycerides in this disorder.

Type II: Dietary management involves reduction of cholesterol intake to less than 300 mg a day and the substitution of polyunsaturated (P) for saturated (S) fats to achieve (P/S) ratio of approximately two (see Table 1). Outlined below is a simple and effective dietary program. All meats (except the leanest), dairy products (except cottage cheese or skimmed milk), egg yolks, and most commercial sweet bakery goods are replaced by seafood, chicken, and turkey (especially without skins), nonhydrogenated vegetable oil margarines, shortenings, cooking and salad oils (labels must be read carefully). If eggs, brains, sweetbreads, butter, and fish roe are eliminated and meats, kidneys, liver, and shellfish are modestly reduced in amount, dietary cholesterol intake poses no problem.

Table 1: Dietary Treatment of Hyperlipidemia

Type of Hyperlipidemia	Total Calories	Distribution of calories		Restriction of particular fats	
		Fat	Carbohydrate	Cholesterol	Saturated Fats
I	—	25 to 35g	—	—	—
II	—	—	—	300 mg	P/S = 2
III	Reduce to and maintain ideal body weight	40% of calories	40% of calories Eliminate free sugar	300 mg	Reduce saturated fat intake
IV	Reduce to and maintain ideal body weight	40% of calories	40% of calories Eliminate free sugar	300 to 500 mg	Reduce saturated fat intake
V	Reduce to and maintain ideal body weight	25% to 30% of calories	50% of calories Eliminate free sugar	—	—

— Indicates no restriction

A reduction of 10% to 20% in serum cholesterol can be expected in most subjects within one month of such dietary modification. The diet is particularly effective in subjects with acquired hypercholesterolemia and in children who are heterozygous for Type II disease. In adults with familial Type II, dietary measures produce small reductions of serum cholesterol and must be combined with drug therapy. The drugs that have been used to treat hypercholesterolemia include cholestyramine, clofibrate, D-thyroxine, nicotinic acid, and sitosterols.

Cholestyramine, 16 to 32 gm daily, is presently the most effective agent for lowering serum cholesterol levels. However, many patients object to its taste and odor. In addition, constipation is a troublesome side effect and high doses may produce steatorrhea.

Although more effective in the treatment of hypertriglyceridemia, clofibrate *(Atromid-S)* lowers serum cholesterol by 10% to 15% in some patients, and by considerably more in an occasional patient with a Type II disorder.

D-thyroxine *(Choloxin)*, 4 to 8 mg daily, reduces serum cholesterol levels by an average of about 15%. Its therapeutic value may be outweighed by side effects which include diarrhea, nervousness, and angina pectoris. D-thyroxine is contraindicated in patients with angina pectoris, a history of myocardial infarction, or hypertension. This drug also potentiates the effects of oral anticoagulants. Accordingly, a cautious trial of D-thyroxine is recommended only after other measures prove ineffective.

Sitosterols *(Cytellin)*, plant sterols which are poorly absorbed and tend to inhibit cholesterol absorption, promote a modest reduction of serum cholesterol. This agent is essentially free of adverse effects, but its effectiveness is slight.

Intravenous infusion of low molecular weight dextran produces a dramatic fall in serum cholesterol which may persist for 6 to 14 days. Although it

has been used extensively in the Baltimore area, such treatment requires frequent infusions and cannot be recommended until its safety and long-term effectiveness are better documented. Finally, ileal bypass may be considered in patients whose marked hypercholesterolemia is unresponsive to the measures outlined above.

Type III: As indicated in Table 1, the main elements in dietary management are maintenance of ideal body weight, control of carbohydrate intake (especially free sugar and foods containing concentrated sweets), and restriction of dietary cholesterol. Clofibrate, 2 gm daily, is the drug of choice in this disorder. When combined with dietary measures, this agent is highly effective in lowering serum lipid levels in patients with Type III hyperlipidemia. In patients receiving warfarin anticoagulants, clofibrate may prolong the prothrombin time so that a reduction in the anticoagulant dose is usually necessary. The drug rarely produces side effects, but weight gain, acute myositis, mild nausea or diarrhea, or a skin rash may occur in a few patients.

Type IV: Dietary management is almost identical with that of Type III (see Table 1). Clofibrate is the most effective drug, but serum triglycerides respond less in Type IV than in Type III. Nicotinic acid decreases triglycerides in Type IV disease and also lowers serum cholesterol in some patients with Type II disorder. The daily dose is increased over several weeks from 1 gm to 3 to 6 gm. At this dose, nicotinic acid often has prominent side effects which include flushing, pruritus, gastrointestinal symptoms, abnormal liver function tests, hyperglycemia, and hyperuricemia.

Type V: Dietary measures (see Table 1) include maintenance of ideal weight, and restriction of fat intake to 25% to 30% of calories and of carbohydrate intake to 50% of total calories. More severe fat restriction may be required to prevent pancreatitis in some patients. Alcohol should be avoided since it may produce marked elevations in serum triglyceride levels. Clofibrate may reduce serum triglyceride levels in some patients with Type V. Successful control of serum triglycerides and prevention of acute pancreatitis was achieved in most women in a small series with the use of the progestational agent norethindrone acetate, 5 mg daily.

Many patients with Type IV have some degree of glucose intolerance. In these subjects, oral hypoglycemic agents or insulin may help to control the hypertriglyceridemia. When insulin deficiency is profound, Type I or Type V hyperlipidemia may occur. Insulin treatment will rapidly clear the chylomicronemia in such patients.

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NEIL SOLOMON, MD, PhD, SECRETARY

Maryland State department of health and mental hygiene

Care of the Aged

NEIL SOLOMON, MD, PhD
Secretary of Health and Mental Hygiene

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Assistant Secretary of Health and Mental Hygiene and Scientific Affairs

Recently, in a licensed nursing home in Baltimore city, an explosive outbreak of salmonellosis resulted in gastrointestinal disease in 108 of 140 patients. Among the 108 ill patients, there were 25 deaths. All afflicted were elderly persons. This outbreak prompted us to consider some of the major issues concerned with the care of the aged which require urgent attention both at federal and local levels.

The medical and health care problems of the aged are prime issues for public concern. However, they have yet to be adequately recognized in terms of effective management. In Maryland, 13,000 beds are occupied by aged patients in nursing homes, while another 2,000 aged patients are housed in the state mental hospitals. In addition, not less than 1,000 chronic disease hospital beds are set aside for subacute and rehabilitative care of the disabled aged. Here, then, are 16,000 beds and associated facilities occupied by aged patients requiring long-term care.

By contrast, we have a total of approximately 12,000 beds in Maryland's general hospitals. It would not be an exaggeration to state that 30% of these beds are occupied by our aged citizens. Note, then, the overwhelming significance of the aged in the medical affairs of our community. Has this situation always existed and, if so, what is unique about it?

The preeminent position of the medical care problems of the aged is relatively new. The aging of the population has been going on for several decades. But it is only recently, and particularly since the establishment of the medicare program, that the public has become a dominant factor in meeting the urgent medical needs of the aged.

While the public concern with and commitment to medical problems of the aged has increased enormously, the concept of structuring this concern into an effective and efficient effort has received inadequate attention. For example, an additional 5,000 nursing home beds have been added in Maryland in the past six years. However, a home health service program to treat these additional patients has only expanded 40%. Other methods of caring for the aged have not been significantly developed.

The relationship among the resources provided by the physician and other community sources of care, the acute hospital, the chronic disease hospital, the mental hospital, and the nursing home has been left to chance. This is indeed a sad picture for our elderly citizens. The most expensive form of care, permanent institutionalization, is becoming the major investment in treating the aged.

With these concepts in mind, we in Maryland plan to recognize the medical and health problems of the aged with the same sense of urgency afforded mental health and environmental health problems. A distinctive agency to deal with the medical services for the aged will be created. This agency will be concerned with the:

(1) Management of the chronic disease hospitals within the jurisdiction of the state

(2) Development and enforcement of standards of care in nursing homes

Prepared for presentation to U.S. Senate Subcommittee on Long-Term Care, August 19, 1970, Washingon, D. C.

(3) Vigorous promotion of home health service programs and their use by practicing physicians

(4) Creation of options to permanent institutionalization such as day care and short-term care in nursing homes

(5) Establishment of regional geriatric screening centers where elderly patients proposed for admission to state mental hospitals or to nursing homes may be evaluated and referred for the most appropriate treatment

(6) Evaluation of services rendered and expenditures made under the medicare program

The personnel for the proposed agency are presently found in different units within our department. They will be organized to efficiently serve the aged. We will need additional staff to enforce standards of care in nursing homes and to be creative in seeking options to permanent institutionalization. We think that we can generate the staff and this form of programming at a state level.

However, there are several developments at the federal level which are still uncertain. Now before the Senate Finance Committee is HR 17550. Among the provisions of this bill, Section 225 would, under Medicaid (Title 19), reduce the federal matching share following 90 days of skilled nursing home care, and would drastically reduce the federal participation in the long-term care rendered in the state's mental hospitals. There is an unfortunate attitude prevailing in some federal circles that by a mixture of incentives and deterrents, unilaterally determined, a system of care can be contrived which is in the best interest of our people. What is proposed in Section 225 would be disastrous for forward thinking on problems of the care of the aged. The state would be called upon to pick up huge dollar obligations for long-term care abandoned by the federal government. In so doing, every possibility to undertake innovation and improvement would be ruined by the necessity to divert funds to replace federal failure to maintain a stable contractual relationship.

In this connection, we would also take issue with the social policy implications of recent legislation designed to categorize care in such a way that patients requiring nursing services with 24-hour nursing supervision come within the purview of medical care (Title 19). Patients requiring nursing services with less than 24-hour nursing supervision come within the purview of public assistance (welfare).

Further, we would submit that this nation cannot do justice to the medical care needs of its people by pursuing radical new departures every two years. Having launched medicaid in 1966, we are subjected to retrenchment in medically indigent coverage. We are asked to undertake an involved modification of long-term care by the insertion of the notion of intermediate care. We are now threatened with retrenchment in federal support of long-term care, while at the same time, we learn that an absolutely new program may be offered in fiscal 1972. Meanwhile, several years later, the initiation of national health insurance would appear a distinct likelihood.

We would suggest that the federal-state partnership set forth in Title 19 (medicaid) be permitted to represent the working apparatus to improve health services to the low-income population until a national uniform coverage is provided. Financial wizardry should be minimized. Professional competence in management at state levels should be maximized.

The philosophy of divide and conquer by developing independent health programs aimed at the economically disadvantaged, ie, Title V programs, OEO programs, Model Cities programs, family planning programs, etc, is a disservice. The medicaid program should be the means by which a system of care for the poor is created. In time, this system may hopefully be part of a nationwide national coverage for all of our citizens.

New Programs for the Mentally Retarded

In the past ten years, there has been a change of attitude among the citizenry of Maryland regarding the problem of mental retardation. Prior to that time, the retarded were isolated from the rest of society. They were housed in rurally located institutions and separated from the mainstream of community life. As long as their basic physical needs were met, the great majority of people were apathetic to the numerous problems created by institutionalism and the need for community programs.

However, isolation of the retarded in large institutions has only increased the cost of care and has deprived retardates of their chances for happiness and self-fulfillment. In addition, the institution has kept them from returning to the community. Generally, these large facilities have been overcrowded, costly to maintain, and lacking in programs. It is now recognized that two of the best ways to provide services for the mentally retarded are to keep as many retardates as possible in the community so that they remain an integral part of the family and society, and to drastically reduce the number of persons in residential institutions.

A Directorate of Mental Retardation was created for the purpose of unifying Maryland's programs for the retarded. The Directorate is responsible for developing, coordinating, and maintaining the programs. All services for the mentally retarded which were formerly administered under the Departments of Mental Hygiene and Health are now the responsibility of the Directorate of Mental Retardation. In addition, this new department will work closely with local and state organizations in making plans for the future.

An important part of the continuum is a good prevention program. At this time, Maryland is giving much attention to the development of such a program. Such measures as improved prenatal programs, inoculations against rubella, food programs for expectant mothers, genetic counseling for parents, and medical examinations utilizing amniocentesis will reduce the percentage of retarded individuals in the future. However, with the increasing population, the overall number of mentally retarded people will continue to rise.

Just as important as a prevention program is the continuing supportive services needed by the family. These services will help the family understand the retardate's development. The family physician, pediatrician, or local health nurse are usually the first people to be contacted when parents suspect their child is retarded. In cases where the parents do not suspect mental retardation, the responsibility of telling the parents and referring the child to the appropriate services may be handled by the local physician or the school. The Directorate of Mental Retardation, if contacted, can aid in the selection of the most appropriate resource for the child and in this way offer service to local individuals or communities.

Once the child's condition has been diagnosed and an evaluation completed, community programs must be available. These programs must meet the different ability levels and home situations of the retarded. The programs must be comprehensive enough to provide for the retardate's changing needs throughout his life.

Day care centers, which provide training for the young retardate, are being expanded every year. Through this program, the child is then able to remain in the home while attending a center to receive training in basic self-care skills such as dressing, toileting, and acceptable behavior. The family is given counseling so that they can help with the training at home.

The type of training offered by the day care centers is basically of two types. There are preschool programs for children ages three to six, focusing on self-help and social development. For those children six to sixteen, who do not fit into an established school program, training in socialization, recreation, and other activities are varied according to the retardates' abilities and needs.

Many young and older adults will continue to need services outside the home; therefore, Maryland is developing activity centers to meet these needs. To these centers, in addition to those who have grown up in day care centers, will come referrals not only from trainable classes but from residential programs.

In these programs, older retardates receive advanced training in basic self-help skills, social skills, and recreation programs. The retardate is taught to be a contributing part of the family. Prevocational programs are also offered in many activity centers so that the retardate can participate in a sheltered workshop. In short, the mentally retarded person is given the skills necessary for him to function in the home and community. If it is felt that he can function adequately in a work situation, the Department of Vocational Rehabilitation will offer work training and needed supportive services.

However, there are still those mentally retarded individuals who may need residential programs for short- or long-term care. Some may be referred because of medical problems; others may be referred because of the inability of their families to care for them.

Regional residential facilities are being constructed in Maryland. Since these centers will be near the retardates' homes, parents will be able to maintain close relationships with their children. The staff of the centers will counsel parents in the areas of care, feeding, and behavioral management. With the close proximity of the centers, it will be routine for the retardate to go home for weekends or short visits when the family and the center feels that it is appropriate. The available space can be used for short-term crisis intervention and thereby reduce the need for long-term care.

Some of the retardates who have lived in residential facilities gain enough self-care and social skills so that they no longer need the constant supervision that the residential center provides. Many others acquire vocational and social skill and are able to function in the community with minimal supervision. Halfway houses have proven to be quite successful for these people. Maryland is presently expanding its program of halfway houses and foster homes for the retarded. In this way, retardates are able to remain or return to the mainstream of community living.

Maryland has taken action which will benefit the mentally retarded. The establishment of a Directorate of Mental Retardation will provide the leadership necessary to develop programs for the mentally retarded and their families. It will also be responsible for providing or procuring services that will include prevention, parent counseling, day care, residential programs, and halfway houses.

The Care of the Mentally Subnormal

Maryland currently requires 1,098 hospital beds for the retarded in addition to available capacity to meet the state's estimated minimum need. Although construction at Rosewood, the opening of Henryton, and the transfer of 100 residents to Mt. Wilson has provided space for 930 patients since 1960, this has largely been balanced by the increased need resulting from Maryland's burgeoning population. The average size of the patient population is now 13.1% above rated bed capacity, a reduction from the 20.3% noted in 1960.

FISCAL YEAR	RATED BED CAPACITY*	AVERAGE SIZE OF PATIENT POPULATION	EXCESS PATIENTS	ESTIMATED BED NEED**	ADDITIONAL BEDS NEEDED
1960	1,873	2,254	381	3,017	1,144
1962	1,873	2,400	527	3,166	1,293
1964	2,073	2,616	543	3,353	1,280
1966	2,564	2,888	324	3,551	987
1968	2,624	3,089	465	3,692	1,068
1970	2,762	3,123	361	3,860	1,098

*** BASED ON AN AVERAGE OF 70 SQUARE FEET OF BED SPACE**
**** ONE BED FOR EVERY 1,000 ESTIMATED TOTAL STATE RESIDENTS AS RECOMMENDED BY THE AMERICAN ASSOCIATION ON MENTAL DEFICIENCY**

A new facility, opening soon near Silver Spring in the Washington metropolitan area, will have an initial capacity for 230 patients. Additional planned construction at Rosewood and in a number of smaller units in different sections of the state will provide space for approximately 700 patients. However, since the minimum bed need will increase to 4,002 by 1972, Maryland will still have an estimated deficiency of at least 310 beds when the current building program is completed.

The above data provide one indication of the need for expanded support for mental retardation programs. Other available indices* show that Maryland, in comparison with other states, ranked 23 in average expenditure for each patient, 30 in the number of beds for each 1,000 total residents, and 32 in the ratio of personnel to patients. On each of the above factors, Maryland was below the national average.

In order to meet the needs of Maryland's rapidly growing population most effectively, the department is centralizing administration of all services for the retarded. Its responsibility, in addition to maintenance and staffing of existing and planned facilities, should include: 1) research and preventive programs for reducing the incidence of mental retardation; 2) increased training and educational programs for the retarded to permit maximum development of their potential; and 3) establishment and expansion of closely coordinated community centered services such as day care centers, halfway houses, sheltered workshops, group care homes, small residential facilities, and other substitutes for hospitalization.

** National Institute of Mental Health-Provisional Patient Movement and Administrative Data-Public Institutions For the Mentally Retarded, July 1, 1967-June 30, 1968*

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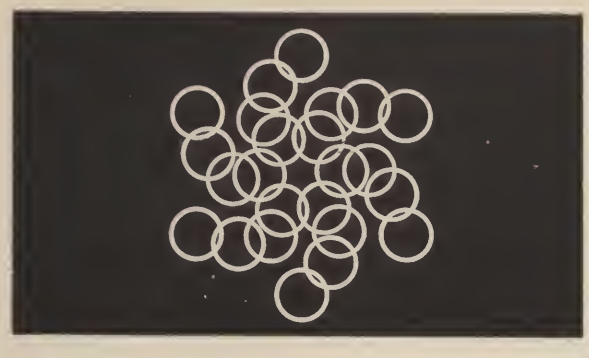
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

The Maryland Alcoholism Program

MAXWELL N. WEISMAN, MD
Director, Alcoholism Control Division
State Department of Mental Hygiene
Baltimore

Dr. Weisman: The time is certainly ripe for a massive attack on alcoholism. It has come about through the work of the Senate Subcommittee on Labor and Public Welfare, the interest of Congress as a whole, and the concern of the courts. The focus that industry is beginning to place on uncovering its alcoholic employees and treating them as sick people, as well as the proliferation of community health and mental health centers throughout the country also serve to combat the problem. I cannot refrain from adding that I hope the other states will follow Maryland's lead in passing legislation similar to ours. I am indeed proud to be a Marylander in being able to point to our state's leadership in this area. I must, however, apologize for not having had time to prepare a written statement for submission to you, Senator, and the committee, and will beg your indulgence for speaking extemporaneously.

We in the state alcoholism programs throughout the nation feel strongly that the bill now pending before Congress will actually be a "Bill of Rights" for the sick and suffering alcoholics in our country. But we have often been promised beautiful programs in grandiose terms, without the opportunity to implement them effectively by realistic funding. I sincerely hope, therefore, that Congress will appropriate the money to make these dreams come true.

As one who has worked closely with treating sick patients, I know that the millions of alcoholics across the country must be tired of hearing professionals like myself hide behind the lack of funding as an excuse for our own ineptness in developing programs and our own deep lack of motivation.

I speak from sad experience. We were faced with a similar situation here in Maryland. Our Comprehensive Intoxication and Alcoholism Control Act was passed in 1968, and went into effect on July 1 of that year without a single cent appropriated toward the excellent program delineated in the law!

Without any funding during that first year, we went directly to the local health departments, to the grass roots where alcoholics live and work and get sick, and worked with them in developing the necessary programs.

In Baltimore city, in 1964, there were more than 15,000 arrests for drunkenness. In the first ten months of 1969, only slightly more than 3,000 alcoholics came in contact with the police and correctional agencies and only about 500 of them were charged with disorderly conduct. Of those remaining, one half were sent home by the police and the other half were brought to general hospitals for treatment because they were incapacitated.

Presented at a hearing before the Special Subcommittee on Alcoholism and Narcotics of the U.S. Senate's Committee on Labor and Public Welfare. The hearing was on the proposed "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970". This alcoholism bill, introduced by Senator Harold Hughes of Iowa for himself and 48 fellow senators, calls for a comprehensive federal program for the prevention and treatment of alcohol abuse and alcoholism. The Senate has passed the bill unanimously and a similar one is now being considered by the House of Representatives, (HR18875) introduced by Rep. Staggers (W. Va.)

This was a significant and welcome relief for the police and law enforcement agencies. But because the lack of funds prevented the development of local services to treat alcoholics, there was an enormous increase in state hospital admissions of alcoholics. In the State of Maryland, more than 50% of the admissions to state hospitals are alcoholics. Alcoholism represents the largest single diagnosis and dramatically exceeds admissions for schizophrenia or any other diagnosis.

Our small staff of three professionals in the Division of Alcoholism Control focused on educating the community about alcoholism. This, too, resulted in enormously greater case finding and referral of alcoholics for treatment than had taken place before the law was passed. Unfortunately, adequate alternative facilities were not yet available in the community and admissions to state hospitals swelled. From the inner city, 66% of all admissions to state hospitals are for the diagnosis of alcoholism.

The communities certainly felt the pressure because in the second year the Maryland Legislature did appropriate a small sum for alcoholism control. As a result, services are now proliferating for alcoholics. Outpatient services, for example, quadrupled as of December 1969, compared to what they were in December 1968.

Fifty percent of the general hospitals in Maryland are now admitting alcoholics under that diagnosis, a phenomenon which had not existed before our law was passed.

Perhaps the greatest lesson we have learned in Maryland, from our need to develop services without funds, lay in the innovative staffing pattern we developed perforce and by design.

We are utilizing nonprofessional alcoholism counselors in addition to other, more traditional professional groups such as the clergy, the public health nurses, the general practitioners, the probation officers, and the social workers to staff alcoholism clinics.

In Hagerstown, the alcoholism clinic operates without a single expensive psychiatrist or physician. It is staffed by one public health nurse, one trained alcoholism counselor who is a recovered alcoholic, and a volunteer.

This one small clinic, within a year and a half, has 60 alcoholics on its rolls and I am sure that the results of this treatment are not inferior to that provided by other clinics where more expensive personnel are employed. In fact, my clinical impression is that it is quite effective.

What I think is indispensable is the appointment, in every local health department, of a full-time alcoholism coordinator who will be responsible for exploring and using local facilities that are already available for alcoholics. He will also be responsible for using existing services for the treatment of people who desperately need treatment and who have been neglected for so long.

Let me cite as an example one county in Maryland, St. Mary's, with a population of less than 45,000. Within one year, what resulted from the appointment of an alcoholism coordinator in the county health department is that every general practitioner there now treats alcoholics.

The alcoholism coordinator has made arrangements with these general practitioners not to turn alcoholics away, because the general hospital will now also routinely admit them for treatment in the regular medical services. Moreover, this hospital is staffed by the regular hospital personnel.

In the first three months of 1970, 38 patients were admitted to this hospital and ten were treated in the emergency room from which they were directly discharged.

The alcoholism coordinator visits the hospital daily and gets referrals from the nurses throughout the wards of those patients admitted as alcoholics, so that a case finding is immediately done. The coordinator can then counsel these alcoholics and their families. He has also been able to use members of Alcoholics Anonymous as "hospital sitters" with alcoholics. This lightens the burdens of the scarce nursing personnel, while, at the same time, transmitting some of the AA members' own expertise as alcoholics in handling other alcoholics.

Likewise, in that county, 215 alcoholics who had been discharged to the community from state hospitals were referred to the coordinator. They came from the courts, from the general hospitals, from the Department of Social Services, from public health nurses, from the clergy, and from the schools. In every case, this coordinator counseled not only the alcoholic, but when a family was available, the family as well.

The coordinator reports that more than 3,000 junior and senior high school students were involved in discussions about alcoholism. This was not simply education about the nature and effects of alcohol as part of the regular school curriculum. It went beyond this into discussions of alcoholism per se, and the development of responsible behavior in a drinking society.

In addition, this coordinator has organized single-day training programs for the professionals, and in that small county, more than 100 professionals have attended such day-long training programs. He has also conducted public, town hall forums about alcoholism with more than 250 in attendance. And I am informed that he is sending 16 of his county's residents to our week-long Institute of Alcohol Studies at Hood College in Frederick.

This man, himself, is a recovered alcoholic, and has been doing the kind of job we hope to see duplicated throughout the state in every other county. Already, in the City of Baltimore where the problem is greater, of course, a similar program is being introduced with a much larger staff of personnel.

I would like also to relate the experience of The Johns Hopkins Hospital, which had not acquired fame in the past for the treatment of alcoholics, although there were many alcoholics admitted throughout the hospital under other diagnoses. There was, however, no specialized focus on this illness anywhere in the hospital.

In a similar development at The Johns Hopkins Hospital, alcoholism counselors and an alcoholism nurse-coordinator were appointed to the staff. In the present fiscal year of 1970, 920 alcoholics were specifically referred to these counselors for treatment; 64% of them came from the emergency room, 34% came from the medical service, and 2% came from other services in the hospital.

Two thirds of all of these alcoholics accepted referral for follow-up care, 127 of them were sent to what we call a quarter-way house—really an extended care facility from The Johns Hopkins emergency room. Actually it is a Flynn Christian Fellowship Home, a private, nonprofit group in The Johns Hopkins vicinity which has contracted with the hospital so that 12 beds are set aside for referrals from the hospital. Those patients who are too sick to be sent out in the street, but are not sick enough to occupy a hospital bed, are referred to this home with the result that, to date, 127 of them have been treated.

The Department of Social Services pays $5 a day for the care of such patients in this quarter-way house, a sum which compares with the state hospital rate of $13 a day, and The Johns Hopkins Hospital bed cost of $92 a day.

From July 19, 1969 to December 31, 1969, the hospital estimates that close to $6,000 was saved through this program. There is also an Alcoholics Anonymous group which now meets in The Johns Hopkins Hospital.

A year ago, no such program existed at The Hopkins for the specific care of alcoholics suffering from acute intoxication. We are now duplicating this pioneer program at the University of Maryland Hospital, and in a short time we hope similar quarter-way houses will be set up in other general hospitals, including the Provident and the City Hospitals.

These are some of the lessons we have learned in Maryland which may be helpful in answering the question, "Who is to do the job set out in your program?"

Our experience points out the essential fact that state and local responsibility for the care of alcoholics must be assigned. When you assign such local responsibility, I feel it must be in the mainstream of American medicine and social welfare.

I would like to briefly outline some guidelines that we have been using in the State of Maryland. As law enforcement and correctional agencies are being phased out of the management program of alcoholics, there needs to be authorized personnel to pick up the alcoholics and to direct them into more appropriate channels.

These personnel, as I have said, should be in the mainstream of public health and social welfare agencies. I am only too well aware of the fact that psychiatry has in the past also neglected alcoholism, but at the same time it has been the principal light focusing on the problem as a disease entity. It was the father of American psychiatry, Benjamin Rush, who first called it a "disease" in 1785. It is listed in the *American Psychiatric Association Diagnostic Manual* as "alcoholism addiction". I think psychiatrists must continue to be involved, but we must also galvanize the vast health and social welfare personnel in our country as well.

Since the present generation of health personnel are not prepared to help alcoholics because they are relatively uninformed, even misinformed (I learned very little about alcoholism in the professional schools I attended), priority must be given to education so that these professionals can play their appropriate roles.

At one of the first meetings we held in Maryland, a social worker complained that no funds were available for her activity in the field of alcoholism. One of our local legislators refused to accept this criticism stating that the social worker was already being paid to help sick and troubled people, and that alcoholics came under that category. What was needed was to learn how to help these people as a prelude to accepting them.

It is a necessary priority then, I think, to educate the people who are already involved, and to introduce alcoholism content into the curricula of professional schools.

Since this is a public health problem, it seems to me that local leadership should be vested in the local health departments, and that emphasis should be given to alcoholism in this area of programming.

With the experience of community mental health centers and comprehensive health centers in decentralizing the treatment of illness back into the community, the treatment of alcoholics should likewise be decentralized. I feel that funding should be much more closely determined by the local and regional personnel than by more distant national areas.

The community mental health centers should make a full range of services available to alcoholics, preferably by the addition of alcoholism counselors on their staffs. Because of the valuable experience of AA and Alanon, and the fellowships generally, I think nonprofessional staffs should be added to every health department and agency.

While AA will continue to be the primary resource in this country to help alcoholics, I think that it is important for public health leadership to develop its own expertise to do the things in program development that Alcoholics Anonymous cannot, and perhaps should not, provide. These include: early case-

finding; early diagnosis; management of the drinking alcoholic who perhaps will continue to drink in spite of the proliferation of services; medical care, which Alcoholics Anonymous certainly cannot give; training of professional personnel; and research so that we may learn more about the mysteries of alcohol addiction.

All alcoholics are motivated to seek treatment. In my experience, I have never come across an alcoholic who is not hurting and who does not want help. I think it is time to motivate the professionals to take their rightful place in the treatment of alcoholism.

I think, too, that we professionals who work with alcoholics have an enormous advantage that no other illness I know of can lay claim to, ie, the existence of thousands of volunteers, many of whom are themselves recovered alcoholics or the wives and husbands of alcoholics, who are ready to place their knowledge and their devotion in the service of suffering humanity.

Senator Hughes: Thank you very much, Dr. Weisman. I am rather glad that you did not have a prepared statement. It was an eloquent presentation. I want to extend my congratulations to you for your program in Maryland and the enlightened approach to alcoholism in many of the cities of Maryland.

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Aids for Hearing 84
Allied Florists Association .....Cover 3
American Office Equipment Co., Inc. 112
Arch Laboratories 112
Arundel Federal Savings & Loan Assoc. 34
Baltimore Nurses Exchange 108
Baltimore Oxygen Supply Co., Inc. 100
Becton Dickinson & Co. 15-16
Belvedere Hotel 100
Bio-Dynamics 57-58
Breon Laboratories 55
Bryman School 84
Burroughs Wellcome & Co. 87
Campbell Soup Co. 45
Capital Savings & Loan Assoc. 108
Oscar Caplan & Sons 8
Cobb-Woods Services 112
Connecticut Mutual Life Insurance Co. 7
Herbert Cox—Correct Shoes 34
Credit Service International, Inc. 34
Dulaney Towson Nursing & Convalescent Home .. 33
Eleven East Chase Street Corp. 18
Embassy Dairy 93
Esplanade Apartments 112
Franklin Uniform Co. 56
Herget & Co. 93
Hoffmann-Green Leasing 100
House in the Pines Nursing Home 60
Hynson, Westcott & Dunning, Inc. 1
Lederle Laboratories 2, 12, 54
Eli Lilly & Co. 4
Martin Motors, Inc. 27
Med-Chi Insurance Trust 90
Milton Inn 18
Monarch Lincoln Mercury 83
National Drug Co. 29-30, 97-98
Pielke Landscape Service 33
Wm. P. Poythress Co., Inc. 88
T. Rowe Price Growth Stock Fund 94
Geo. Radebaugh & Sons 11
Read's Drug Stores 18
Resinol Chemical Co. 53
A. H. Robins Co. 20-21, 35-36
Roche Laboratories .....22-24, 50-51, Cover 4
Manuel Schwartz Hearing Rehabilitation 86
G. D. Searle Co. 46-47
Security Business Services, Inc. 84
Special Diet Shop 17
State Sun Federal Savings & Loan Assoc. 89
Sterling Lighting Co. 27
Stuart Co. 48
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 8
Timonium Chrysler Plymouth 11
Tio Pepe Restaurant 89
Towson Telephone Secretaries 33
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(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., 58:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., 18:410-415, May 1970.



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VOLUME 19 DECEMBER 1970 NUMBER 12

CONTENTS:

The Need for Continuing Education, Robert J. Thomas, MD 64

"At the Frederick Memorial Hospital, a program recognizing the need for continuing education has been developed. This unique program seeks to afford intellectual stimulation to the medical community of Frederick."

Histoplasmosis, Henry V. Chase, MD 65

"The purpose of this article is to discuss histoplasmosis as it is found in Maryland, Virginia and, more recently, the District of Columbia. Some scientific studies made in these areas will be presented, along with some of the history of the disease. Some comments concerning diagnosis are included, as well as a few general remarks about the treatment of the disease."

Shigella and Salmonella Infections in Frederick County, Charles G. Spicknall, MD, FACP 71

"Salmonella and shigella infections have been the greatest problem in communicable diseases in Frederick County in the past three years. While no deaths have occurred, these diseases have been a major cause of illness."

Q Fever, Russell L. Guest, MD 73

"A review of the cases of rickettsial disease experienced at the Frederick Memorial Hospital during the period 1959 to 1969 was performed recently. The case records indicated that Rocky Mountain spotted fever was diagnosed in 13 cases and recovery was achieved in 12 of them. One patient died."

The Lymphocyte, Robert J. Furie, MD 75

"The biology of the lymphocyte has become one of the most exciting stories in contemporary medicine. For most of us, having been out of medical school for some years, the small lymphocyte is a cell in the 'white cell' series, about which we were taught little."

Postoperative Wound Infections, Robert J. Thomas, MD 77

"In the history of surgery, a major period of significant advance took place when an understanding of the role of bacteria in wound infections led to remedial practices. This period of success was achieved by the employment of strict practices aimed at reducing the opportunity for infection, from within or from without."

Exploratory Laparotomy in Fever of Unknown Origin, Rex Martin, MD 79

"It has been established that about 40% of patients with fever of unknown origin will eventually develop features which will permit a diagnosis to be made. About half of these problem cases will recover without having had a diagnosis established. Ten percent of this group will continue to be febrile, without a diagnosis being reached."

Semiannual Business Session Minutes and Reports 81

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 90

Tuberculosis—Skeletal Tuberculosis 93

Heart Page—The Work Evaluation Unit of the Heart Association of Maryland, Donald H. Dembo, MD 95

Rehabilitation Notes—Patterns of Medical Care in a Municipal Hospital, Douglas G. Carroll, MD 97

Baltimore City Health Department—Clinics Open, Aides Meet, and Medical Workers Join Staff 101

Alcoholism Page—Treatment of Acute Alcoholism: Part 1, Nelson J. Bradley, MD 105

Library Page—Library Co-Sponsors Meeting; New Accessions 109

DITORIAL and BUSINESS OFFICE: 211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

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ON THE COVER: Shown is the Francis Scott Key grave in Frederick. This is the only place in the country where the flag is supposed to fly 24 hours a day. The cover photo, as well as the contents in this month's issue, where contributed by the physicians of Frederick County.

Doctors Take Note 5

Executive Director's Newsletter 9

Annual Meeting News 13

MEDIC 16

Book Reviews 23

1970 Semiannual Meeting Highlights 25

1971 Semiannual Meeting News 29

Statement of Controlled Circulation 34

Component Society News 35

Annual Meeting Art and Hobby Exhibit Form 37

Woman's Auxiliary 39

Annual Meeting Scientific Exhibit Form 41

Board of Medical Examiners 42

Annual Meeting Hotel Reservation Form 47

Information for Authors 48

Medical News 51

The Month in Washington 56

Classified Advertising 115

Advertising Index 116


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Scientific Winter Cruise on *S.S. Rotterdam*—Combines shipboard sessions with sectional meeting in Panama City, Caracas, and San Juan. Contact: American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

JANUARY 5-20, 1971
DEPARTMENT OF POSTGRADUATE MEDICINE, ALBANY MEDICAL COLLEGE

12th Postgraduate Medical Seminar Cruise: A 15-day cruise from New York aboard the luxurious and distinguished ship "Gripsholm" of the Swedish American Line. Ports of call will include San Juan, Dominica, St. Vincent, Trinidad, Barbados, Martinique, and St. Thomas. Contact: Girard J. Craft, MD, Department of Postgraduate Medicine, Albany Medical College, Albany, N.Y. 12208.

JANUARY 7-9, 1971
AMERICAN CANCER SOCIETY

National Conference on Cancer of the Colon and Rectum: Hotel del Coronado, San Diego, California. A broad multidisciplinary presentation will be made by leading authorities in epidemiology, etiology, detection, diagnosis, and treatment. Programs and approaches to control this disease will be discussed. Contact: Ronald N. Grant, MD, Vice-President for Professional Education, American Cancer Society, 219 East 42nd St., New York, N.Y. 10017.

JANUARY 13-15, 1971
AMERICAN COLLEGE OF PHYSICIANS/AMERICAN HEART ASSOCIATION

Postgraduate Course—Coronary Atherosclerotic Heart Disease: Emory University School of Medicine, Atlanta, Georgia. Contact: Registrar. Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

JANUARY 13-15, 1971
AMERICAN COLLEGE OF CHEST PHYSICIANS

Postgraduate Course—Intensive Respiratory Care for Nurses, Inhalation and Physical Therapists: Vail, Colorado. Contact: American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

JANUARY 15-17, 1971
AMERICAN COLLEGE OF CHEST PHYSICIANS

Postgraduate Course—X-ray Description of Pneumoconiosis: Pittsburgh, Pa. Contact: American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

JANUARY 18-22, 1971
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Recent Advances in Internal Medicine: Augusta, Georgia. Contact: American College of Physicians, 4200 Pine St., Philadelphia, Pa.

JANUARY 20-22, 1971

AMERICAN DIABETES ASSOCIATION/MAYO CLINIC, MAYO FOUNDATION/UNIVERSITY OF MINNESOTA SCHOOL OF MEDICINE AND HEALTH SCIENCE CENTER

18th Postgraduate Course—Diabetes in Review: Clinical Conference 1971: Kahler Hotel, Rochester, Minnesota. Sessions of the course will include a variety of subjects; workshops are being planned. Registration fee: $75 for members of the association; $100 for nonmembers. The course is accredited by the American Academy of General Practice for 17 hours of elective credit. Among the speakers will be Thaddeus E. Prout, MD, of the Greater Baltimore Medical Center in Baltimore. For further information, contact: J. Richard Connelly, Executive Director, American Diabetes Association, Inc., 18 East 48th St., New York, N. Y. 10017.

FEBRUARY 4, 1971

UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Gynecology Day: University of Maryland, Baltimore, Md. Contact: University of Maryland School of Medicine, 522 West Lombard St., Baltimore, Md. 21201.

FEBRUARY 5-7, 1971

AMERICAN COLLEGE OF PHYSICIANS/AMERICAN ACADEMY OF PEDIATRICS

Postgraduate Course—Recent Advances in Immunoprophylaxis and Chemotherapy of Infectious Diseases: Hilton Inn, 1601 Miracle Mile Strip, Tucson, Arizona. The University of Arizona College of Medicine will participate. For further information, contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

FEBRUARY 7, 1971

MARYLAND THORACIC SOCIETY

11th Annual Scientific Session: Sheraton-Baltimore Inn, Broadway & Orleans Sts., Baltimore, Md. Contact: Mrs. Ruth M. Disney, Administrative Assistant, 11 East Mount Royal Ave., Baltimore, Md. 21202.

FEBRUARY 15-18, 1971

AMERICAN COLLEGE OF CHEST PHYSICIANS

Postgraduate Course—Cardio-Respiratory Care—An Advanced Course for Nurses: Los Angeles, California. Contact: American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

FEBRUARY 20-21, 1971

AMERICAN ACADEMY OF ALLERGY

Postgraduate Course—27th Annual Meeting: Palmer House, Chicago, Illinois. Arthur M. Silverstein, MD, of the Wilmer Ophthalmological Institute of The Johns Hopkins University School of Medicine, Baltimore, Md., will participate in the session on New Developments in Cellular Immunology. Contact: American Academy of Allergy, 756 N. Milwaukee St., Milwaukee, Wisc. 53202.

FEBRUARY 20-27, 1971

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS/COLLEGE OF AMERICAN PATHOLOGISTS

Joint Interim Meeting: The Dunes, Las Vegas, Nevada. Contact: The American Society of Clinical Pathologists, The Secretariat, 710 South Wolcott Avenue, Chicago, Ill. 60612.

MARCH 31, 1971

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH, MEDICAL AND CHIRURGICAL FACULTY/ST. JOSEPH HOSPITAL

Symposium—Emergency Room Medicine: St. Joseph Hospital, Towson, Maryland. Contact: Medical and Chirurgical Faculty, 1211 Cathedral St., Balto., Md. 21201, or call 310-539-0872.

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executive director's newsletter

December, 1970

ANNUAL MEETING RESOLUTIONS

Resolutions to be considered at the Annual Meeting scheduled for May 12, 13, and 14, 1971 must be in the Faculty office ON OR BEFORE Friday, March 19, 1971.

Faculty Bylaws require that such items of business be submitted at least eight weeks prior to the meeting date.

BOARD OF MEDICAL EXAMINERS RULES AND REGULATIONS

Notice is hereby given that Board of Medical Examiners is revising its rules and regulations covering reciprocity and licensure.

Any communications in connection with such changes should be addressed to:

Board of Medical Examiners
1211 Cathedral Street
Baltimore, Maryland 21201

COMMISSION RULES AND REGULATIONS

The rules and regulations of the Commission on Medical Discipline are being republished. Inquiries regarding these matters should be addressed to the Commission or the Board at the above address.

CONFUSION IN MEDICAL DISCIPLINE

Some confusion exists concerning the responsibilities of the Commission on Medical Discipline.

In medical discipline cases, the local society or the Faculty must conduct the investigation. The members of the Commission then act as judges and consider and act on recommendations made to it by either the local medical society or the Faculty.

PROFESSIONAL CORPORATIONS

There is also some confusion about names applied to Professional Corporations as formed under Maryland statutes concerning such corporations.

The name of one or more of the individual incorporators must appear in the corporate name, followed by the initials "PA", or the words "Professional Corporation".

EXCERPT FROM REPORT

The state's Comprehensive Health Planning Agency, in a report dealing with Certification of Need for Health Services and Licensure, has stated:

"...the Health Services and Facilities Committee recommends that ways be studied to include the private solo practitioner in comprehensive health planning and future legislation."

THINGS TO PLAN FOR

Scheduled programs for coming months include:

January 2, 1971 - Woman's Auxiliary Tour of Hospital Ship HOPE and Reception

January 7, 1971 - 2:30 PM in the Belvedere Hotel. A Medicolegal Symposium will be held in conjunction with the mid-winter Maryland State Bar Associati Meeting. This will be in the form o a mock-trial, involving a back injur and should be of interest to all physicians.

January 14, 1971 - All day seminar dealing with the Whys, Hows and Wherefores of the Drug Abuse Syndrome. (If interested, call Faculty office as reservations are required).

March 31, 1971 - Meeting on Medical Emergency Services

VISITS TO COMPONENTS

The Executive Director has begun making annual visit to Component Medical Societies. Those Societies already visited for the 1970-71 year include Dorchest County, Anne Arundel County and the Maryland ENT Society.

COMPUTER BILLING

1971 dues bills will be in the mail early in December 1970. This year, they will be printed by a computer- if you find a mistake, please let us know so the appr priate corrections can be made.

John L. Sargeant
Executive Director

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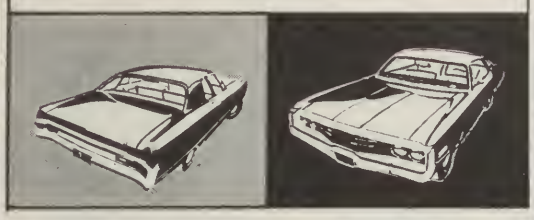
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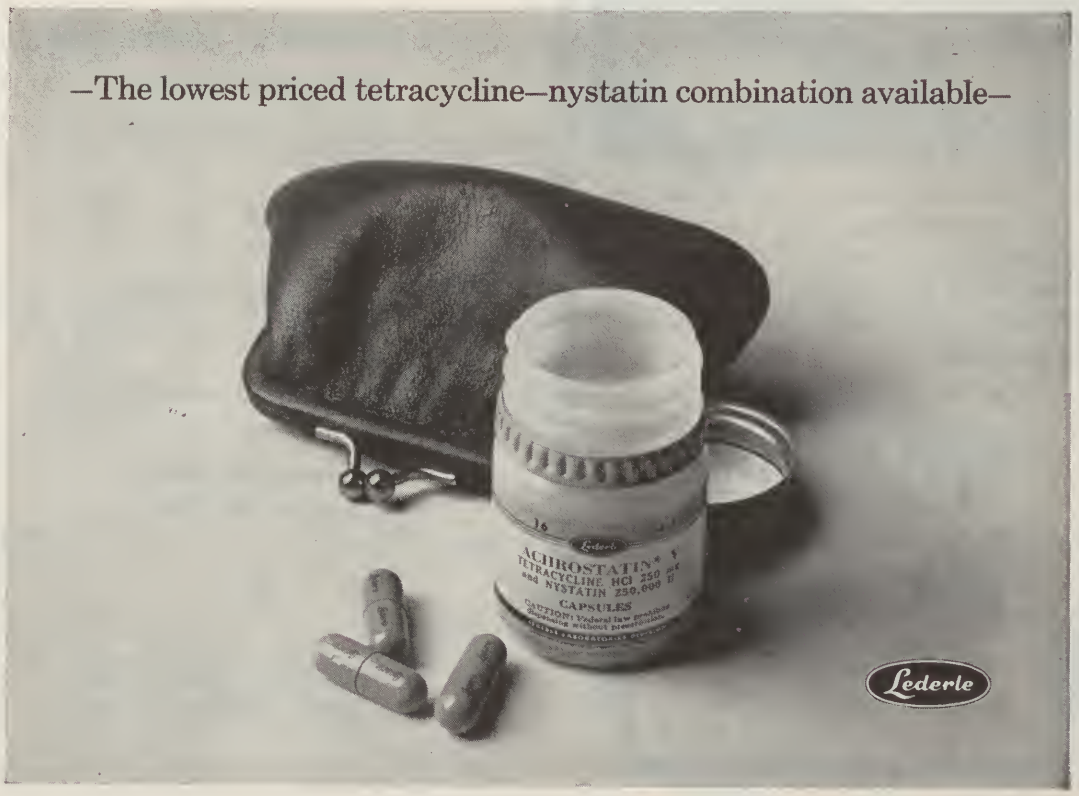
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MAY 12, 13, 14, 1971

173rd Annual Meeting of the Medical and Chirurgical Faculty

at the

BALTIMORE CIVIC CENTER

The scientific sessions will include:

MEDICAL PEDIATRIC GRAND ROUNDS, conducted by **Marvin Cornblath, MD,** Professor and Head, Department of Pediatrics, University of Maryland School of Medicine

SURGICAL PEDIATRIC GRAND ROUNDS, conducted by **J. Alex Haller, Jr., MD,** Robert Garrett Professor of Pediatric Surgery, The Johns Hopkins University School of Medicine

PANEL-SYMPOSIUM on Treatment of the Alcoholic and the Family: Practical Aspects, conducted by **Martin L. Singewald, MD,** Chairman of the Committee on Medicine and Religion of the Medical and Chirurgical Faculty

PAPERS presented by the following nationally eminent speakers:

Alan F. Guttmacher, MD
President, Planned Parenthood
World Population

G. Rainey Williams, MD
Professor of Surgery and Chairman,
Department of Surgery, University
of Oklahoma Medical Center

George E. Schreiner, MD
Director, Nephrology Division,
Department of Medicine, Georgetown
University School of Medicine

Saul Krugman, MD
Professor and Chairman,
Department of Pediatrics
New York University

Lawrence K. Pickett, MD
Professor of Pediatric Surgery
and Pediatrics, Yale University
School of Medicine

Nicholas J. Pisacano, MD
Secretary, American Board of
Family Practice, Inc., University
of Kentucky Medical Center

Edward C. Rosenow, Jr., MD
Executive Director
American College of Physicians

Neil L. Chayet
Counsellor at Law
Boston, Massachusetts

SCIENTIFIC* AND TECHNICAL EXHIBITS will be on display at the Civic Center. Every physician should avail himself of the opportunity to see much of what is new in medicine.

OTHER ACTIVITIES scheduled for the Annual Meeting are:

ROUND TABLE LUNCHEON, Baltimore Civic Center

HOSPITALITY NIGHT, Baltimore Hilton Hotel

PRESIDENTIAL RECEPTION AND BANQUET, Blue Crest North
A dinner-dance with Rivers Chambers Orchestra

ART AND HOBBY EXHIBIT,* Baltimore Civic Center

HEALTH EVALUATION TESTS, Baltimore Civic Center

*Applications for **Scientific Exhibits** and the **Art and Hobby Exhibit** appear elsewhere in this Journal.

Watch the MARYLAND STATE MEDICAL JOURNAL for Further Details

Important Dates — May 12, 13, 14, 1971

Arlie R. Mansberger, Jr., MD, *Chairman*
Committee on Program and Arrangements

PUBLISHED TO REPLACE A PREVIOUS ADVERTISEMENT WHICH THE FOOD AND DRUG ADMINISTRATION CONSIDERED MISLEADING

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus.* GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

Injectable Garamycin®

brand of gentamicin sulfate injection

Schering

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

PACKAGING GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

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MEDIC 1970–1971 SCHEDULE

OF POSTGRADUATE PROGRAMS

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DECEMBER 18, 1970 — 12:30 PM

DRUG ABUSE—THE BARBITURATES

Joseph R. Bianchine, MD
Assistant Professor of Medicine
Johns Hopkins University School of Medicine

Sponsor: BALTIMORE CITY HOSPITALS

Replays: Monday, December 21, 1970 — 12:30 PM
Wednesday, December 23, 1970 — 7:30 AM
9:00 AM
2:00 PM

JANUARY 8, 1971 — 12:30 PM

ORAL MANIFESTATIONS OF SYSTEMIC DISEASE

John F. Hasler, DDS, MSD
Assistant Professor of Oral Diagnosis and Radiology
University of Maryland School of Dentistry

Sponsor: ST. AGNES HOSPITAL

Replays: Monday, January 11, 1971 — 12:30 PM
Wednesday, January 13, 1971 — 7:30 AM
9:00 AM
2:00 PM

JANUARY 15, 1971 — 12:30 PM

SICKLE CELL CRISES

Philip D. Zieve, MD
Assistant Professor of Medicine
Johns Hopkins University School of Medicine

Sponsor: BALTIMORE CITY HOSPITALS

Replays: Monday, January 18, 1971 — 12:30 PM
Wednesday, January 20, 1971 — 7:30 AM
9:00 AM
2:00 PM

JANUARY 22, 1971 — 12:30 PM

THE HYPERACTIVE CHILD

Dennis Whitehouse, MD, MRCP
Assistant Professor of Pediatrics
Johns Hopkins University School of Medicine

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays: Monday, January 25, 1971 — 12:30 PM
Wednesday, January 27, 1971 — 7:30 AM
9:00 AM
2:00 PM

JANUARY 29, 1971 — 12:30 PM

ALTERATION OF THE HORMONAL MILIEU IN THE MANAGEMENT OF ADVANCED BREAST CANCER

John H. Mather, MD
Department of Surgery
University of Maryland School of Medicine

Sponsor: PENINSULA GENERAL HOSPITAL

Replays: Monday, February 1, 1971 — 12:30 PM
Wednesday, February 3, 1971 — 7:30 AM
9:00 AM
2:00 PM

SPONSORS:

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CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAYS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

MEDIC . . .

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

January 26 March 23 April 27 May 25

To be broadcast over MEDIC

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
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Cumberland Memorial, Cumberland
Easton Memorial, Easton
Edward McCready, Crisfield
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Frederick Memorial, Frederick
Good Samaritan, Baltimore
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The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Physicians Memorial, La Plata
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

Other locations:

Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
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Did You Know?

- Workers who smoke as much as a pack of cigarettes a day spend a third more time away from their jobs because of illness than do people who have never smoked, government studies show.

- When you inhale a cigarette your blood pressure goes up. Your heart beats 15 to 25 times extra per minute.

- By switching from cigarettes to a pipe you can cut your risk of a heart attack to that of a non-smoker. But you increase the risk of cancer of your lips and tongue, but not your lungs.

- Smokers average 15% more days of illness in bed than those who have never smoked. For heavy smokers (more than two packs a day) the rate is 1½ times higher among males, and 2½ times higher for females.

- In 1900, per capita consumption of cigarettes was 54 annually. By 1968 it was 4,195.

- A greater risk of unsuccessful pregnancy is experienced by women who smoke.

- Life expectancy among young men is reduced by an average of eight years among heavy (over two packs a day) cigarette smokers and an average of four years among light (less than half a pack a day) smokers.

- Cigarette smoking is the most important cause of chronic bronchitis in the U.S.

- Your risk of a heart attack, even sudden death, are three times as great if you smoke 20 cigarettes a day as they are if you do not smoke—or smoke a pipe or cigar.

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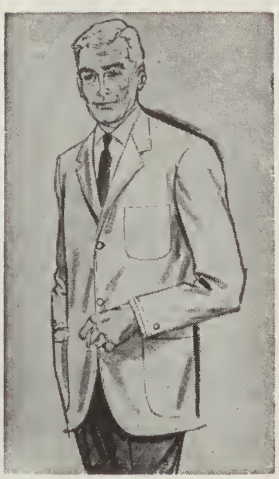
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414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

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310—Sanforized Twill Jean **$5.99**

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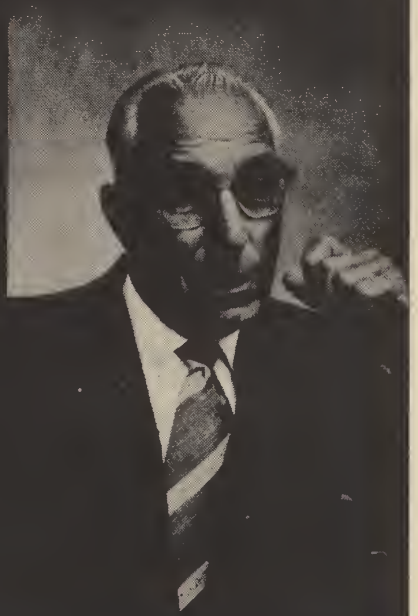
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"Drug research gives me the tools that save lives."



A family doctor looks at new developments in the pharmaceutical industry. And he speculates on the future.

When I look back at some of my old records, I'm constantly reminded of the changes that have come about in medicine just during the past twenty-five years. Some of the diseases I treated and prayed over in the '40's are found mostly in medical history books now.

Thanks to drug research and development, we've made substantial gains in the control of cardiovascular disease, diabetes, malaria, mental illness, strep and staph infections, meningitis and a long list of ailments. It seems like only yesterday when a diagnosis of pneumonia was almost the kiss of death. Now, with modern medical techniques and drug therapy, we can offer some real help.

My records on polio, influenza and measles show an unbelievable trend for the better. New vaccines have reduced the toll of these age-old threats dramatically. And I see patients in pain from crippling arthritis helped with new medicinals unknown just a few years ago.

I hear questions about the three billion or so dollars spent by the drug industry in research during the past ten years . . . working on new and better drug products. It does seem like quite a bit of money to spend, and I realize some of it goes into dead ends. That's the problem with research, any research . . . you often don't know where you're going until you get there. I want all the tools I can get to help my patients. I want more drugs and more effective drugs. If they mean less pain, longer lives and more productive careers for those I treat . . . well, that's what really counts.

Another point of view . . .
Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N.W., Washington, D.C. 20005.

This advertisement has been reaching consumers thru THE ATLANTIC, FAMILY HEALTH, HARPER'S MAGAZINE, NEWSWEEK, SATURDAY REVIEW, TIME and U.S. NEWS & WORLD REPORT.

Roche announces

Efudex®

(fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex®(fluorouracil)—a new alternative to conventional therapy

Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



/2/68—After 11 days of treatment. rythema is seen at site of keratoses. In ddition, numerous lesions not apparent rior to therapy have become manifest y sharply defined reactions. Intervening kin, also treated, shows no response to ierapy.

/19/69—One year after cessation of ierapy. Skin appears clear with no evi- ence of scarring. Examination reveals ck of recurrence or the formation of ew lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new Efudex® (fluorouracil) cream/solution



For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence: erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions with complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 7[illegible] lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 3[illegible] of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

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Book Reviews

ESSENTIALS OF CLINICAL ENDOCRINOLOGY, Norman G. Schneeberg, MD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

This book is designed for the individual who is untutored in endocrine matters and who seeks a didactic introduction or brief review of this subject. Clinical features are stressed, with particular emphasis on the practical aspects of therapy.

It is not planned as a reference manual or as a bibliographic repository. Dr. Schneeberg has called on many outstanding contributors in this work, which is well worth having in your library.

ATLAS OF NUCLEAR MEDICINE, Lung and Heart, Volume 2, Frank H. DeLand, MD; and Henry N. Wagner, Jr., MD; The W. B. Saunders Company, Philadelphia, Pennsylvania, 1970.

This volume contains discussions of cardiac as well as pulmonary diseases as studied with static images. Included also are images from the new procedure of nuclear angiography, which is proving increasingly useful for evaluating heart, lung, and vessel circulation.

This book should be of great interest to internists, and to those who are actively specializing in this area of radiology.

SYNOPSIS OF ANATOMY, Liberato J. A. DiDio, MD, PhD; The C. V. Mosby Company, St. Louis, Missouri, 1970.

The editor, along with the nine contributors to this publication, offer a more than adequate case presentation for synthesizing the important aspects of anatomy and streamlining these aspects into a fairly compact volume.

By so doing, they have conceived an informative, concise, and integrated text.

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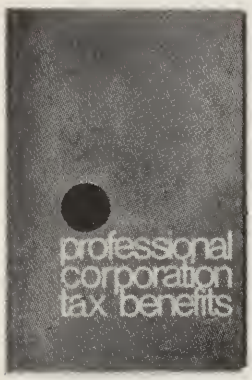
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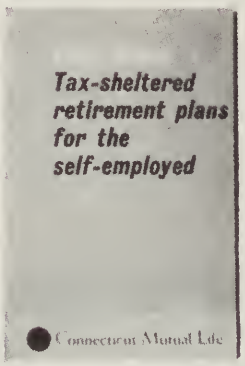
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M*I*S*H*M*A*S*H

1970 semiannual meeting fun night

Physicians of all specialties participated in some good-natured lampooning when the Woman's Auxiliary staged its annual entertainment during the Semiannual Meeting at Hotel Hershey this past September.

One of the highlights of the program, arranged by Vandy Bauer, was a skit entitled M*I*S*H-M*A*S*H, during which the physicians themselves, portraying their peers, literally brought down the house.

Another show-stopper was Dick Bauer in a Shelly Berman-type telephone conversation. Dick was monologuing Executive Director, Jack Sargeant, in hypothetical yet true-to-life conversations with the governor, committee chairmen, and the complaining public.

Other scene stealers were: Angela Linhardt at the piano; Vandy Bauer as a slightly addled woman's club program chairman; and Mrs. George S. Banning and Mrs. John O. Sharrett depicting the ambiguity of PTA messages sent home.

Basic to the performance of M*I*S*H*M*A*S*H, an original script written by Jeanne Sargeant, was a parade of specialists, acting and re-acting to ambivalent lyrics re-written to familiar music by Hilary Sargeant, Angela Linhardt, and John Graham. These songs, with their original words, were sung by a chorus of seven: Mrs. Connie Galton, Mrs. Harold Biehl, Mrs. Charles Bagley, Mrs. Martin Strobel, Mrs. Joanne Ptak, Miss Terry Bromwell, and Miss Hilary Sargeant.

The show got off to a rollicking start with a rendition of "Hey, Big Spender". This was dedicated to all physicians, since they are so regarded by the public. "So let me get right to the point, I don't pop my cork for any old MD. Hey, big spender, spend a little time with me."

Then Pete Peterson, as a radiologist, paraded to "I'll be seeing you in all the old familiar places that this negative encases . . ."

John De Hoff, as that friendly delivery boy, the obstetrician, was musically hailed with "By the time I get to Hopkins, she'll be ready. She'll find the note I left hanging on my door. She'll laugh when she reads the part that says I'm leaving, cause I've missed that girl so many times before. . ."

He was followed by Aaron Sollud as the gynecologist, to the musical accompaniment of "Believe me if all those endearing young charms. . ."

Talmadge Reeves was a smash as the pediatrician. He wore little boy shorts and was consoled by both a huge lollipop and a pacifier as the chorus sang, "On the Good Ship Lollipop."

At this point, the ubiquitous general practitioner broke up the audience in the first of three running appearances as he dashed through with his medical bag to the plaint of his patients: "If it takes forever, we will wait for you." Emanuel Schimunek was the only medico cast in his own specialty.

Next appearing as the glamor boy of medicine, the cardiologist, Elmer Linhardt embraced a huge cardboard heart as the chorus intoned: "I left my heart in Houston, Texas; from Baylor U. it calls to me to be where red and white corpuscles go flowing through my muscles. My morning booze will chase the blues so I don't care. . ."

Ray Yow, with a mallet and a bottle of spirits, embodied the anesthesiologist to the tune of "Mr. Sandman," including the plaint, ". . . Mr. Sandman send me a dream, sodium pentathol to ease the pain."

After this, Joe Harrison, with ape mask and mirror, cavorted on stage to depict the plastic surgeon to the tune of "Baby Face".

"Dry Bones" brought the orthopod on stage in the person of Phil Briscoe, complete with skeleton. Then Charlie O'Donnell appeared with plunger, cable, and umbrella to depict the urologist as the chorus offered "Raindrops Keep Falling on my Head."

Andy Mitchell with catsup-stained T-shirt, cleaver, and knife was acclaimed as the surgeon with "Bloody Jerry is the man I love, Bloody Jerry is my surgeon, too, now ain't that too damn bad. . ."

The show came to a wild conclusion when John De Hoff, as the psychiatrist (What Kind of Nut Am I?), quivered on stage with all his hang-ups embodied in a security blanket to which Talmadge Reeves as the pediatrician lay loud vocal and physical claim.

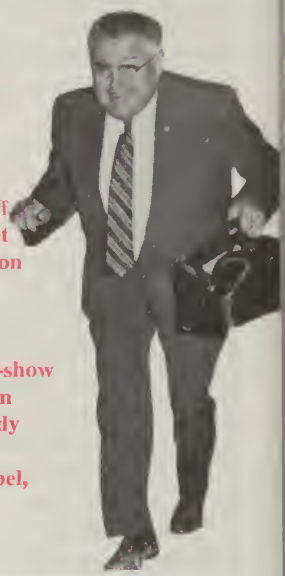
Post show music was presented by Ferdinand Kaden in a free-wheeling-play-it-by-ear concert.

(Continued on next page)









Fun seemed to be the theme of this year's Semiannual Meeting Entertainment Night staged by the Woman's Auxiliary at Hotel Hershey. This page (top to bottom, left to right): Dick Bauer monologuing Jack Sargeant; lollipopped pediatrician Talmadge Reeves; pianist Angela Lindhardt; GP Emanuel Schimunek dashing across the stage; psychiatrist John De Hoff complete with security blanket; and (from left): anesthesiologist Ray Yow, Emanuel Schimunek, Elmer Lindhardt, plastic surgeon Joe Harrison, skit narrator John Graham, and gynecologist Aaron Sollud. Opposite page (top to bottom, left to right): urologist Charles O'Donnell; cardiologist Elmer Lindhardt, with cardboard heart; Ferdinand Kaden, who supplied the post-show music; Mrs. George Banning, Mrs. Vandy Bauer, and Mrs. John Sharrett; and chorus members (next to bespattered surgeon Andy Mitchell): Mrs. Connie Galton, Mrs. Harold Biehl, Mrs. Charles Bagley, Miss Hilary Sargeant, Mrs. Martin Strobel, Mrs. Jo Ann Ptak, and Miss Terry Bromwell















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Time to Take Stock

MARYLAND STATE MEDICAL JOURNAL, published monthly by the Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore, Maryland 21201. C. Thomas Flotte, MD, Editor; Debby Anderson, Managing Editor. Editorial offices—1211 Cathedral Street, Baltimore, Maryland. Owned by the Medical and Chirurgical Faculty of the State of Maryland. No known bondholders, mortgages, or other security holders. Total numbers of copies printed—4400 (average number of copies each issue during preceding 12 months), 4400 (actual number of copies of single issue published nearest to filing date). Paid circulation through dealers and carriers, street vendors and counter sales—none, through mail subscription—4122 (average number), 4125 (actual number.). Total paid circulation—4122 (average), 4125 (actual). Free distribution (including samples) by mail, carrier, or other means—226 (average), 227 (actual). Total distribution 4348 (average), 4352 (actual). Office use, left-over, unaccounted, spoiled after printing—52 (average), 48 (actual). Sum total—4400 (average), 4400 (actual).

ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Board of Directors Meets

The October 13, 1970 meeting of the Board of Directors was called to order by the acting chairman, Philip F. Wagley, MD, at 4:30 PM.

The minutes of the September 8 meeting were approved as distributed.

Mr. Ronald Elwell, Specialist, Family Life Education, Baltimore City Public Schools, discussed the present sex education program in the city schools. The Board, after lengthy discussion with Mr. Elwell, felt that the general membership of the Society should be informed of the activities taking place in the schools in this area. Mr. Elwell was invited to speak to the Society at the December 3 meeting and give an outline of the program.

The suggestion was also made that a committee be set up by the Society to investigate this program in greater detail and make recommendations concerning its content to the public school administration.

Richard L. London, MD, treasurer, presented the following report of the Finance Committee which was approved by the Board.

The Finance Committee recommends that:

(a) An audit of the amount paid to the Medical and Chirurgical Faculty for rent and services be requested from the Faculty's comptroller.

(b) $15,000 presently in a 4¾% interest account at the Savings Bank of Baltimore should be withdrawn and placed in a high-yield account.

(c) $10,000 presently in a 5% certificate account at First National Bank should be withdrawn at maturity and invested in Treasury bills.

(d) All interest should be placed in a savings account and, when an appropriate amount is accumulated, it should be invested in stock funds.

Copies of the Policy and Planning Committee Annual Report were distributed for the information of the Board and will be available to the membership at the December meeting of the Society.

The contract with Mr. William Evans to act as parliamentarian for the Society for the coming year was approved. It was mentioned that Mr. Evans performed in an outstanding manner in the past and the Society should extend its appreciation to him.

The Board discussed the merit of sending a representative to the luncheons of the Chamber of Commerce and agreed that unless the topic were of interest to the medical profession, no representative would be sent.

The Board declined to endorse the Loan Question appearing on the November 3 general election ballot which would support a Harbor Campus for the Community College of Baltimore.

No nomination for the Organization Achievement Award given yearly by the Health and Welfare Council was proposed.

Correspondence from Oakley H. Saunders, MD, informed the Board of problems he had encountered in establishing a Well-Baby Clinic for the Baltimore City Health Department in his office. Dr. Farber commented that these problems were being discussed with Dr. Saunders and it was expected that the major points of disagreement had been settled. However, Dr. Saunders also indicated that he would like to have the agreement publicized and the Board suggested that Dr. Saunders be invited to the next meeting to present his views.

Dates for the 1971 general meetings and Board of Directors meetings were approved. The dates are as follows:

Baltimore City Medical Society General Meetings

Thursday, January 7, 1971, 8:30 PM
Thursday, February 4, 1971, 8:30 PM
Thursday, March 4, 1971, 8:30 PM
Thursday, April 1, 1971, 8:30 PM
Thursday, October 7, 1971, 8:30 PM

Thursday, November 4, 1971, 8:30 PM
Thursday, December 2, 1971, 8:30 PM

Board of Directors Meetings

Tuesday, January 12, 1971, 4:30 PM
Tuesday, February 9, 1971, 4:30 PM
Tuesday, March 9, 1971, 4:30 PM
Tuesday, April 13, 1971, 4:30 PM
Tuesday, May 11, 1971, 4:30 PM
Tuesday, June 1, 1971, 4:30 PM
Tuesday, July 13, 1971, 4:30 PM
Tuesday, August 10, 1971, 4:30 PM
Tuesday, September 14, 1971, 4:30 PM
Tuesday, November 9, 1971, 4:30 PM
Tuesday, December 14, 1971, 4:30 PM

Dr. Wagley informed the Board that Dr. Classen was presently in the process of forming a Peer Review Committee and would have further information at the next meeting.

Due to insufficient information, the Board was unable to discuss the problem of physicians referring patients to emergency rooms for treatment in their absence. Further information will be available for the next Board meeting.

A letter of appreciation was noted from Mrs. Alexander Cochran, recipient of the Community Service Award.

There being no further business, the meeting was adjourned at 6:30 PM.

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Entries should be delivered to the Baltimore Civic Center, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, May 11, 1971. They must be removed on Friday, May 14, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit. All entries should be submitted as early as possible.

A Hobby Corner at the Semiannual Meeting of the Faculty in Hershey created a great deal of interest. LET'S MAKE IT A REAL "SHOW" FOR THE 1971 ANNUAL MEETING. SUBMIT YOUR ENTRIES NOW!



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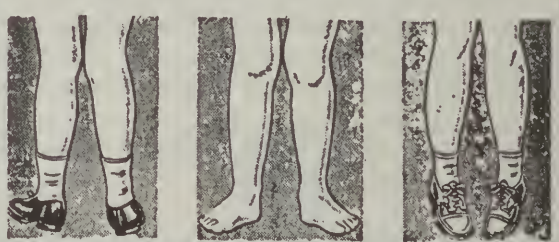
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MRS. ROBERT W. GARIS, EDITOR

woman's auxiliary

Letter from the President

Dear Doctor—Yes, YOU,

I often wonder if you ever take time to scan the auxiliary page of your state journal. It is designed with you in mind. If your wife is a member of the auxiliary, she receives her newsletter, HYGEIA FILIAE. If your wife isn't a member yet, I hope you are letting her peek in the journal to find out what we, as physicians' wives, are doing for you, her husband.

You really have an abundance of women working to help you in community programs, to stimulate interest in preventive medical care, to assist in immunization programs, and to try to improve your public image and that of your colleagues. We also attempt to foster good will and fellowship between physicians' families. As you well know, when one marries a doctor, he or she becomes an integral part of the medical profession whether they like it or not, and our individual actions reflect on our fellow members of the medical profession.

The purpose of the auxiliary page in the journal is to acquaint you with our programs and progress in specific areas. I believe you might like to know that we have active committees working on AMAERF, Children and Youth, Community Service, Disaster Preparedness-Safety, Doctor's Day (to show everyone how proud we are of you), Health Careers, International Health Activities, Legislation, and Mental Health, plus other committees concerned with public relations and the Auxiliary to the Student American Medical Association.

We have the programs designed to assist you; we have the enthusiasm to carry these programs out. We need your understanding of our purpose, and your wife's support. As with all volunteer work, more hands lighten the load.

May I just mention that if you've been taking a hard look at proposed legislation, attitudes of the news media, problems of communication, just to list a few, I don't need to tell you that our almost 1,000 members (out of a possible 3,800) are needed to do for you what *must* be done to improve relationships in all areas.

I strongly urge your wife to join us if she isn't a member yet. We need her support, her shoulder, and her talent to accomplish our goal of serving your community.

I'm glad I've had this opportunity to visit with you. The ensuing issues will tell you more about some of our programs. Please take time to read them.

Most sincerely yours,
Margaret Yow, President

Annual Fall Conference News

Amid bubbling good humor, congeniality, and the greeting of old friends, registration of delegates to the 27th Annual Fall Conference of the Woman's Auxiliary to the AMA occupied Sunday afternoon of October 11, 1970, in the French Room foyer of the Drake Hotel in Chicago, Illinois. Delegates were separated into four regional divisions: Eastern, Northcentral, Southern, and Western. Get-acquainted dinners were held that evening with each regional division assigned to a different dining room. Likewise, each regional division was given a separate meeting room throughout the conference.

After opening exercises and assorted greetings on Monday morning, October 12, the conference opened with the keynote address by Ernest B. Howard, MD, executive vice-president of the American Medical Association. His theme was an attempt to answer the question of maintaining the quantity of medicine while giving quality care and the accessibility or availability, or both, of such care. His presentation of

the AMA's "medicredit", with its inclusion of a Peer Review Organization (PRO) as against Senator Kennedy's National Health Insurance bill was, indeed, thought-provoking. I hope our Med-Chi members will have the opportunity of listening to Mrs. Yow's tape of the speech. Dr. Howard maintained that physicians must have an acceptable PRO plan ready to go into operation or be subject to a Federal Review Board. Senator Bennett of Utah has already presented a bill for medical review boards which would exclude physicians entirely.

Dr. Howard touched on several other subjects causing concern to the AMA. Among them was public relations. The AMA is considering an institutionalized advertizing campaign throughout the country which would be wholly positive and noncontroversial. Beginning in January 1971, the AMA will sponsor an hour-long TV program with Art Linkletter as master of ceremonies.

From political economics, we switched to home economics. Effie O. Ellis, MD, special assistant for Health Services to the AMA, earnestly told the assembled delegates that "nutrition controls how we feel, how we act and how we look". She developed this theme in a discussion-type presentation with AMA's Director of Foods and Nutrition, Philip White, ScD. They discussed the part that malnutrition in pregnancy may play in mental retardation, on the necessity of caloric balance in any attempt to increase male longevity, and the part overweight in infancy may play in the later development of obesity.

The president and president-elect of WASAMA then thanked Auxiliary members for their courtesies and friendships and for pointing the direction toward achieving their goal.

The morning session concluded with a defensive driving presentation by Mr. Raymond Martinez, Director of Training for the National Safety Council Driver Improvement Program. When he had finished his lively and vigorous delivery, most listeners felt that they wanted to enroll in a defensive driving course as soon as possible.

The President of the American Medical Association, Walter C. Bornemeier, MD, was the guest speaker at Monday's luncheon. His "tongue-in-cheek" presentation on "Relations—Family and Public" was received with laughter by some, and bewilderment by others.

The Monday afternoon session was devoted to a useful demonstration of the technique of presenting an Auxiliary package program. The program used was "Smoking". The speech "To Smoke or Not To Smoke", which is included in the package and is designed for delivery by a physician, was given by Mr. M. T. Enright, Director of the AMA's Speakers Program Department.

The Monday program ended with a dinner sponsored by the AMA Public Affairs Division and AMPAC. Mrs. John M. Chenault, former National Auxiliary President and now a member of the AMPAC Board of Directors, introduced the guest speaker, the Honorable Philip Crane, (R.), U.S. Congressman from Illinois' 13th Congressional District.

Tuesday's session commenced with an "Early Bird" Parliamentary Session, conducted by Mrs. Herbert L. Mantz, Parliamentarian. She stressed five rules that a presiding officer must observe: order, courtesy, justice, right of the minority to be heard, and the will of the majority to prevail. She firmly stated that all presiding officers must remember that power is invested in the office, not in the person presiding, and that all rulings must be made only at meetings. Mimeographed sheets on "The ABC's of the Presiding Officer" were distributed. Mrs. Yow hopes to have one for each county president.

At the conclusion of the parliamentary briefing, the delegates attended miniworkshops for the rest of the morning. Workshop topics were: Children and Youth; Home-Centered Health Care; International Health; Mental Health; Safety-Disaster Preparedness; and Publicity and Public Relations.

The Tuesday luncheon included a "Miss AMAERF" pageant produced by Mrs. Howard Ellis, AMAERF Chairman. The music was provided by Mrs. Virgil Ray Forester. This merry bit of nonsense was received delightedly and was a good example of what county AMAERF committees can do to publicize this project.

The Wednesday session began with a tour of the American Medical Association's headquarters at 535 N. Dearborn Street, Chicago. We were properly impressed by the computers and amazing electronic devices and had a quick peep at the AMA library. The remainder of the morning was devoted to audiovisual presentations in the AMA's ninth floor auditorium. The films shown are available to the counties on request.

Mrs. Robert A. Reiter

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SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

May 12, 13, 14, 1971
Baltimore Civic Center

More space is available than in former years. However, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS

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Baltimore, Maryland 21201

Addendum to Directory of Registered Physicians—

Physicians licensed and registered in Maryland, March 19, 1970 through October 15, 1970

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The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522



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MEDICAL NEWS

Arthur Rudolph Bergman, MD, of Takoma Park, has recently become a Fellow of the American College of Anesthesiologists.

* * *

Emerson Coleman Walden, MD, President of the Maryland Medical Association, was recently chosen president-elect of the National Medical Association at its 75th Anniversary Diamond Jubilee Convention in Atlanta.

Dr. Walden is a former chairman of the board of trustees and a member of the executive committee of the NMA.

* * *

The use of medication to calm overactive school children is strictly a medical matter, according to **Neil Solomon, MD, PhD,** Maryland's Secretary of Health and Mental Hygiene. Dr. Solomon stated that he was responding to a number of inquiries he has received regarding this practice.

According to Dr. Solomon, "Medical treatment is a matter for the personal relationship of the physician and the patient. Any other procedure for the administering of this or any similar drug would be contrary to Maryland law."

* * *

A team of physicians from The Johns Hopkins Hospital won first place for their scientific exhibits at the 75th Annual Meeting of the American Academy of Ophthalmology and Otolaryngology, held recently in Las Vegas.

Arnall Patz, MD, Stephen J. Ryan, MD, Edward Maumenee, MD, Krishnamurthy Sankaranaryanan, MD, and **Terry W. George, MD,** presented the exhibit, "Argon Laser Photocoagulation."

* * *

Members of the **American Academy of Pediatrics' Committee on Environmental Hazards** recently testified before the Senate and House Banking and Currency Committees in support of legislation to eliminate lead-based paint from housing so that the incidence of childhood lead poisoning might be reduced and ultimately abolished.

* * *

William M. Heller, PhD, Bethesda, was recently named the executive director and secretary of the United States Pharmacopeia Convention. This is a newly created post.



Dr. Heller

* * *

The American Academy of Pediatrics recently requested the formation of a **National Advisory Council on Children,** which would be responsible to the President of the United States. The Academy also called for the creation of a voluntary multidisciplinary national health service corps, and a national health insurance program to insure comprehensive coverage for all children.

* * *

Robert C. Abrams, MD, was the chairman and a participant in the James Lawrence Kernan Hospital's 75th anniversary session and banquet held recently.

Among the fourteen physicians presenting papers on modern surgery, treatment, and management of severe orthopedic cases were: **J. Scott Decker, MD, Baltimore; Liebe S. Diamond, MD, Baltimore; Robert E. Chambers, MD, Bethesda; George W. Wharton, MD, Baltimore; T. Hugh Morgan, MD, Baltimore; and W. Haddox Sothoron, MD, Baltimore.**

* * *

May 31, 1971, has been set by Neil Solomon, MD, PhD, Maryland's Secretary of Health and Mental Hygiene, as the target date for the completion of a state-wide massive rubella immunization. Half a million children, from ages 1 through 12, have not yet received this immunization.

Harry M. Meyer, Jr., MD, and Paul D. Parkman, MD, of the Division of Biologics Standards of the National Institutes of Health, Bethesda, the two physicians who developed the rubella vaccine, joined with Dr. Solomon recently at a press conference to discuss the efficacy of the vaccine and the progress on a national level of the rubella eradication program.

* * *

Communication between The Johns Hopkins' house staff, clinical fellows, and administration were strengthened recently when these three groups agreed to the formation of **The Johns Hopkins House Staff Society.** The Society was created to keep the house staff and fellows in-

formed of administrative policy decisions, and to give the house staff greater participation in those decisions.

Officers of the society are: Pat Brookhauser, MD, ENT, president; Sandy Wise, MD, urology, vice-president; Jeff Neill, MD, medicine, secretary; and Jess Thoene, MD, pediatrics, treasurer.

* * *

Stephen B. Hameroff, MD, Ricardo Garcia-Mullin, MD, and John Eckholdt, MD, all of Baltimore, authored an article entitled "Ocular Bobbing" in the October issue of the *Southern Medical Journal.*

* * *

Physicians are urged to request that their patients secure adequate immunization for their children against diphtheria. **Howard Garber, MD,** Chief of the Division of Communicable Diseases, State Health Department, and **Neil Solomon, MD, PhD,** Maryland's Secretary of Health and Mental Hygiene, stated that the outbreak of the disease in Texas has caused some concern here.

Maryland's percentages of DTP (Diphtheria, Tetanus, and Whooping Cough) vaccine administration, however, remain well above the national averages.

* * *

Jacob H. Conn, MD, Assistant Professor Emeritus of Psychiatry at The Johns Hopkins University School of Medicine, received the Gold Medal Award for his contributions to Scientific Hypnosis at the 22nd Annual Meeting of the Society for Clinical and Experimental Hypnosis, held in Philadelphia recently.

Some of Dr. Conn's achievements include developing the Play Interview treatment of fearful children as well as pioneering treatment for sex offenders and sociopaths. He has also authored 105 publications in the fields of psychotherapy, child psychiatry, and hypnosis.

* * *

Robert P. Madden, MD, Chief of the Far Ultraviolet Physics Section of the National Bureau of Standards, was the recipient of the 1970 Stratton Award, it has been announced.

Dr. Madden, who received his PhD from The Johns Hopkins University, was cited for "imaginative use of a high-energy accelerator to open a new and rewarding field of atomic structure research." He resides in Mt. Airy.

* * *

Robert W. Gibson, MD, Medical Director of Sheppard and Enoch Pratt Hospital, delivered the Annual Strecker Award Lecture at the Institute of the Pennsylvania Hospital recently.

At this time, too, Dr. Gibson received the Institute's 1970 Strecker Award in recognition of his concern for patient care and treatment.

* * *

Allan C. Barnes, MD, Baltimore, was elected a nonrotating member of the Executive Board of the Fellows of Obstetricians and Gynecologists at their recent World Congress held in New York.

Dr. Barnes is also a member of the Joint Study Group on the Training and Practice of Midwives and Maternity Nurses.

* * *

The Centurion Club of the Deafness Research Foundation recently announced its list of Maryland professional members. They include: **Cyrus L. Blanchard, MD; John E. Bordley, MD; G. H. Conner, MD; G. T. Nager, MD;** and **M. Lee Williams, MD.**

The Centurion Club's primary purpose is to raise funds to underwrite the administrative costs of the Deaf Research Foundation through annual membership dues from ENT specialists and their professional societies. Support from the medical profession allows other funds received by the Foundation to be used for research and related objectives. The **Maryland Ear, Nose and Throat Society** supports the club.

* * *

David E. Rogers, MD, Dean of the Medical Faculty of The Johns Hopkins University, will be an active participant in a two-day colloquium on the future role of university-based metropolitan hospitals to be held during New York Hospital's 200th anniversary next year.

* * *

The Maryland Society of Internal Medicine recently elected its new officers: They are: President, **Vernon M. Smith, MD;** President-elect, **Gordon Cader, MD;** and Secretary-Treasurer, **Wilmer K. Gallager, Jr., MD.**

Council members elected are: **Barnett Berman, MD; Katherine H. Borkovich, MD; Marvin H. Davis, MD; Thaddeus E. Prout, MD; Martin L. Singewald, MD; and William G. Speed, III, MD.**

* * *

Thomas E. Andreoli, MD, has been appointed director of the Division of Nephrology, Department of Medicine, School of Medicine at the University of Alabama. Dr. Andreoli had formerly served with the Gerontology Section of the National Institutes of Health at Baltimore City Hospitals.

* * *

To provide information that will assist the health professional in dealing with patients' smoking problems, the National Medical Audiovisual Center in Georgia announces the availability of the film, **"Fair Warning".**

For free short-term loan, write: National Medical Audio-

visual Center, (Annex), Station K, Atlanta, Georgia 30324.

* * *

The federal government has assumed the bulk of the personal health care bill for persons aged 65 and over since the inception of Medicare four years ago.

In fiscal year 1969, for example, the average annual medical bill for each aged person was $692, but the average older person's out-of-pocket outlay was only $163, according to Social Security Administration figures.

* * *

Theodore A. Hussey, a former executive in the U.S. Navy Surgeon General's office, has been named assistant director of planning by The Johns Hopkins Medical Institutions.

Mr. Hussey will help develop long-range plans for The Johns Hopkins Hospital School of Medicine and School of Hygiene and Public Health.

* * *

Mead Johnson Laboratories will sponsor a Cancer Chemotherapy Program in 1971.

The Program will consist of lectures to be given by outstanding medical authorities in the field of cancer chemotherapy. Fourteen physicians, all with hospital, university, or clinic affiliations, will deliver the lectures.

Mead Johnson Laboratories will make arrangements for speaker procurement and will defray expenses for honoraria, travel, and lodging. Medical organizations interested in obtaining one of the speakers should contact: Martin E. Vancil, MD, Associate Director, Medical Research Department, Mead Johnson & Company, Evansville, Indiana 47721.

* * *

Eli Lilly and Company is prepared to do anything within its power to help solve the problem of the use of empty gelatin capsules in the heroin trade, according to **Henry F. DeBoest,** vice-president of corporate affairs.

Testifying before the House of Representatives Select Committee on Crime, DeBoest said that the company has procedures aimed at ensuring that its output of empty capsules remains in legitimate channels.

Wholesalers had been asked to screen their orders from retailers in order to satisfy themselves that there was a legitimate need for the products. In addition, the company was screening orders from its wholesalers when quantities in their orders appeared unusual.

DeBoest pointed out that production of the number five small capsule, which reportedly was being used for packaging heroin, represented less than 1% of the company's total capsule production.

* * *

The nation's second oldest medical group has voted to change its name of 23 years. The American Academy of General Practice, the national association of family physicians, now will become known as the **American Academy of Family Physicians.**

* * *

A guide for all concerned with the medical, administrative, or judicial aspects of programs for the disabled is available without charge, upon request from the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn Street, Chicago, Ill. 60610.

* * *

Children with diabetic blood relatives develop diabetes at a much higher rate than do children who do not have diabetic blood relatives, according to a report in the current issue of the *Disease Detection Newsletter.*

The report highlights the findings of a pilot project started at the University of Missouri's School of Medicine.

* * *

A stay at The Johns Hopkins Hospital is less frightening to sick children these days thanks to a coloring book that tells what to expect.

The coloring book, published with support from the Women's Board of the Hospital, is given free to all children admitted, and may also be purchased in the gift shop.

Written by **Mrs. Barbara Schuyler Hass,** former director of Child Life Development at Hopkins, the book is illustrated by Lun Harris of the Maryland Institute of Art.

The book's 45 pages are full of easily understandable advice for hospitalized youngsters. In addition, there is a hospital scene to color on every other page.

* * *

Additional federal funds for rubella vaccine, totaling nearly $269,000, have been assured Maryland for the coming fiscal year.

This extra financial assistance should enable the state to complete the important job of eradicating German measles, which the medical community began last year.

According to **Karl Green, MD,** chairman of the Steering Committee on Immunization Practices of the Medical and Chirurgical Faculty of Maryland, the state medical society fully endorses this type of program in order to insure the protection of those still susceptible to the disease.

* * *

The Diabetic Health Center for Children recently opened at **Happy Hills Hospital** here. The purpose of the center is to provide diabetic children and their families with a continual pro-

gram of education based on specific needs of each patient and family. The program will enroll private and indigent ambulatory patients who are not acutely ill, and will stress the proper methods of dietary care, insulin injection techniques, urine testing, and parental attitudes in the general care of the child with diabetes.

The program has the approval of the Maryland Diabetes Association and the State Health Department. It will be under the supervision of a full professional staff.

Referrals may be made to Robert B. Schultz, MD, Diabetic Health Center for Children, 1708 West Rogers Ave., Baltimore, Md. 21209.

* * *

A *Bibliography of Sports Medicine* has been published by the American Academy of Orthopaedic Surgeons.

Compiled by the Academy's Committee on Sports Medicine, the 96-page volume is identified as an introduction to the interdisciplinary literature for physicians and others handling athletes and athletic programs.

The book is available at $2 a copy with quantity discounts. Write: Publications Committee, American Academy of Orthopaedic Surgeons, 430 North Michigan Ave., Chicago, Ill. 60611.

* * *

The American Cancer Society has commended **Maryland Blue Cross and Maryland Blue Shield** for their public service advertising campaign in radio, TV, and newspapers aimed at creating public awareness of the need for periodic cancer checkups.

Edward F. Lewison, MD, past president of the Maryland Division of the American Cancer Society, and chief of the Breast Cancer Clinic at The Johns Hopkins Hospital, presented a special citation to Blue Cross officials. It cited the health insurance company for setting an example which could be followed by many advertisers in bringing important health problems to the attention of Maryland citizens.

The President of the American Cancer Society, **Jonathan Rhoads, MD,** joined Dr. Lewison in making the presentation.



Receiving a special citation from the American Cancer Society for their corporation's advertisements promoting cancer checkups are, from left, Thomas Sherlock, Senior Vice-President of Maryland Blue Cross and Denwood Kelly, President of Maryland Blue Shield. Presenting the special citation is Edward F. Lewison, MD, Past President of the Maryland Division of the American Cancer Society. Looking on is Jonathan Rhoads, MD, President of the national American Cancer Society, Inc.

Moses S. Koch, former president of Essex Community College, joined The Johns Hopkins Hospital staff recently as the hospital president's Consultant for Allied Health Education Planning.

Dr. Koch will review all existing Johns Hopkins programs in the allied health sciences. He will work with universities, junior colleges, and public schools to develop broader and better educational programs in medical technology, radiologic technology, nursing and other paramedical health professions.

* * *

The **Direct Relief Foundation** announces available information for those physicians who are interested in working in or visiting hospitals overseas.

Presently, work assignments are available in Central and South America, The Far East, South Asia, and Africa.

For information, write: Direct Relief Foundation, 27 East Canon Perdido St., Santa Barbara, Calif. 93101.

* * *

A recent monograph from the Institute of Rehabilitation of the New York University Medical Center entitled *Urological Nursing Procedures, Rehabilitation Monograph 43,* summarizes the latest techniques in the management of incontinent patients. The publication, aimed at both medical and paramedical personnel and at the patient himself, reflects ten years of research and clinical experience at the Institute of which **Howard A. Rusk, MD,** is the director.

Written by **John Whelan, RN,** nursing supervisor in urology, in cooperation with **Ellen Coffman, RN,** director of nursing, and **Rosario Donnarumma, MD, RN,** formerly assistant director of nursing education, the monograph includes explanation of various treatment procedures, appliances, and personal hygiene.

It may be purchased for $2 a copy from the Publication Office, Institute of Rehabilitation Medicine, 400 East 34th St., New York, N.Y. 10016. Make checks payable to New York University Medical Center.

* * *

As an initial step in tightening Maryland's regulation of nursing homes, and to provide additional guidance and assistance to nursing home operators, **Neil Solomon, MD, PhD,** Secretary of Health and Mental Hygiene, announced the appointment of **Ferdinand A. Korff** as Special Consultant on Food Hygiene.

Mr. Korff, who served from 1933 to 1965 as Director of the Bureau of Food Control of the Baltimore City Health Department, will undertake the studies of adequacy of food purchasing, preparation, and distribution procedures within nursing home facilities.

* * *

The continually increasing demand for health personnel on all levels, opportunities for career advancement, and the personal satisfaction of helping others are featured in **"Horizons Unlimited,"** a 28-minute color film available for loan from the State Department of Health and Mental Hygiene.

This film may be borrowed without charge from the Film Services, Maryland State Department of Health and Mental Hygiene, 301 West Preston Street, Baltimore. (Phone: 383-3010, ext. 8516.) Time should be allowed to preview and to arrange for a discussion leader.

* * *

The National League for Nursing has urged the Department of Defense to offer all registered nurses, regardless of their educational backgrounds, equal opportunity to become commissioned officers in the armed services.

At present, Department of Defense regulations limit nurse officer candidates to graduates of nursing education programs of at least 27 months in length. This eliminates from officer candidacy nurses who graduate from junior and community college nursing programs with an associate degree, and graduates of some hospital diploma nursing schools which have shortened their curriculums.

* * *

The Institute of International Education announces the opening of its annual competition for grants for graduate study or research abroad, and for professional training in the creative and performing arts.

The grants, which will be available for the academic year 1971-1972, are designed to promote mutual understanding between the people of the U.S. and other countries through the exchange of persons, knowledge, and skills. It is expected that there will be at least 554 awards available for this period.

For more information, write: Institute of International Education, 809 United Nations Plaza, New York, N.Y. 10017.

* * *

The Ortho Division of Chevron Chemical Company is advertising in a different kind of medium this fall because they have an unusual message.

The medium is the *Journal of the American Medical Association* and the product is concern. Through its ad, Ortho is offering free distribution of the U.S. government publication, "Directory, Poison Control Centers."

Write: Chevron Chemical Company, 200 Bush Street, San Francisco, Calif. 94104.

* * *



THE MONTH IN WASHINGTON

The American Medical Association challenged charges of widespread tax cheating by physicians and renewed its offer to cooperate with the government in cracking down on dishonest physicians.

In letters to Sen. Russell B. Long (D., La.), Chairman of the Senate Finance Committee, Walter C. Bornemeier, MD, President of the AMA, answered the tax-cheating charges, and Ernest B. Howard, MD, Executive Vice-President of the AMA, renewed the offer of cooperation. But Dr. Howard also said that mandatory reporting of unassigned fees by insurance agencies would be an ineffective and unfair way to try to uncover physicians cheating on their income taxes on payments for their services under medicare and medicaid.

The tax-cheating resulted from testimony given by Meade Whitaker, who then was tax legislative counsel for the Treasury Department, at a hearing of the Senate Finance Committee during its consideration of changes in the medicare and medicaid programs. He said that many providers of services under the two health care programs might have "substantial deficiencies" in their income tax returns.

In a letter to Sen. Long and Sen. Wallace F. Bennett (R., Utah), a ranking minority member of the finance committee, Dr. Bornemeier said that the charges had been widely distorted in the press and that these reports do the medical profession a serious injustice.

Whitaker testified that from an original list of returns from 11,000 physicians who received payments of $25,000 or more for services rendered under medicare and medicaid in 1968, 4,000 returns warranted a detailed audit by the IRS.

With preliminary audits completed on 3,000 of the 4,000 returns, there were indications that 1,500 of these showed "substantial deficiencies", the Treasury reported. "Substantial deficiencies later were defined as being underpayments of more than $100.

Dr. Bornemeier said that this testimony was being widely interpreted to mean either that one third of the medical profession was cheating (4,000 of 11,000 cases to be audited) or that one half of the profession was cheating (1,500 alleged offenders from 3,000 actual audits)

"Assuming the worst—that 1,500 doctors out of 11,000 are guilty of income tax irregularities—the correct proportion would be between 13% and 14% rather than 33% or 50%," Dr. Bornemeier said.

The AMA President called on the Treasury Department to be specific in their charges, since the interpretation by the press growing out of their testimony reflected on the profession as a whole.

"As of now," he continued, "there seem to be 1,500 cases where substantial deficiencies may exist. I think we should know what proportion of these cases simply represents cause for further examination and what proportion represents cases that may realistically be expected to end up with the fraud division of the IRS.

"I think we should know what proportion of the serious cases involve physicians. I suspect the figures given include osteopaths, dentists, pharmacists, and optometrists and others eligible to receive medicare-medicaid payments."

Dr. Bornemeier told Sen. Long that his request for documentation of these cases was not a defense for the dishonest physician or anyone else who attempts to falsify an income tax return.

"We are on record," the Chicago physician said, "as requesting examples of wrongdoing by doctors receiving payments under government health programs so that we may take action of our own."

Dr. Howard said that "the dishonest or incompetent physician hurts us just as much as he harms his government."

Dr. Howard also said that a recent statement by Sen. Long that the AMA had been "completely forthright and honorable, and sought to shield no one" is "exactly our position."

The AMA official also noted that Sen. Long, at a recent hearing of the finance committee, had referred correctly to previous requests by the AMA that it be given examples of suspected chicanery by physicians in government health programs "so that we might take our own action".

As for mandatory reporting of unassigned medical payments—those given to the patient rather than to the physician—Dr. Howard said such a requirement "would not provide the Internal Revenue Service with helpful and meaningful data". He urged rejection of such an amendment proposed by the Treasury Department. A joint House-Senate conference committee rejected it last year in considering tax reform legislation.

The Treasury Department proposed that Blue Cross-Blue Shield organizations, medicare and medicaid agencies, and other health insurance carriers be required to report unassigned payments for medical services.

Dr. Howard pointed out that millions of patients have more than one health insurance policy and may collect total benefits exceeding the physician's charge, and that some patients may not even use the insurance payment to compensate the physician. Physicians also would have to set up costly additional bookkeeping record procedures to list separately and in detail each charge to a patient in excess of $25, the AMA official said.

"The proposal of the Treasury Department would place physicians in a unique category under our tax laws," Dr. Howard said. "We know of no other provision in the tax laws which singles out one class of individual taxpayers, requiring payers to report to the IRS individual payments made to taxpayers as well as the annual aggregate amount of such payments.

"We believe . . . that the proposed . . . amendment is unfair and discriminatory and would do little to accomplish any goal for an improved system. Instead, as an additional cost burden, it would place further pressure on the cost of medical care."

* * *

President Nixon, at a bill-signing ceremony, praised the new Drug Abuse Act for providing "a forward looking program" for treatment of drug addiction as well as strengthening the government's law enforcement powers in the field.

The new law provides for the Department of Health, Education, and Welfare to run extensive programs for the treatment and rehabilitation of drug users and for antidrug education. It authorizes HEW's National Institute of Mental Health to spend $189 million over three years to build and staff treatment facilities, to support rehabilitation programs, and to increase antidrug education programs. Another $1 million is authorized for creation of a presidential commission of marijuana.

State comprehensive health plans getting federal aid must now include drug abuse programs, and an Administration spokesman suggested that all states model their drug control laws on the federal statute.

Before final passage, Congress modified the original legislation to meet many of the objections of the medical profession against a proposal that would have allotted most classification powers and research control to the Justice Department. The attorney general can declare drugs as dangerous but he is bound by HEW's medical and scientific evaluations.

The strengthened enforcement provisions are aimed at the drug pusher with lighter penalties for drug possession, particularly by minors. Federal first offense cases for drug users are lowered from felonies to misdemeanors. Under this provision, a person found guilty of possessing marijuana for the first time will not necessarily be subjected to an automatic stiff jail sentence. But to facilitate arrest of pushers, the controversial "no-knock" clause was retained.

Requirements as to records kept by physicians remain the same as under the old narcotics law except where the physician regularly dispenses a nonnarcotic drug and charges for it.

The new law broadens the former narcotics statute to include, with varying restrictions and controls, amphetamines, barbiturates, and other drugs ruled dangerous. At the start, controls will be drastically tightened over marketing the liquid form of

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amphetamines which can be taken by injection.

Companies producing or distributing a long list of commonly prescribed stimulants, depressants, and tranquilizers will be subject for the first time to federal registration requirements. The Narcotic Bureau also now has a new power to set production quotas for such nonnarcotic drugs.

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, praised Congress and the Administration for enactment of the law:

"Drug abuse has become a frightening problem for millions of Americans. It is absolutely proper for the federal government to exercise this type of aggressive leadership to stem the use of physically and psychologically damaging illicit substances, to control the misuse of legitimate medicines produced for the health and welfare of citizens, and to support rehabilitative needs for victims of the drug problem."

Other health legislation recently enacted into law included:

—The Communicable Disease Control Act of 1970 which authorizes expenditure of $210 over the next three years for vaccination and other control programs against tuberculosis, venereal disease, German measles, measles, polio, diphtheria, tetanus, whooping cough, Rh disease, and other diseases judged by the Secretary of Health, Education, and Welfare to be major problems.

—The Regional Medical Programs and Comprehensive Planning and Services Act of 1970 extending the programs for three years with authorized spending of $545 million for RMP and $52 for CHP. Further appropriations totalling $961.5 million were made for project grants for areawide health planning; training, studies, and demonstrations; comprehensive public health services; and health services development. RMP is expanded to include kidney disease. The new law provides for a systems analysis of national health care plans and for a cost and coverage report on such legislation. A National Advisory Council on Comprehensive Health Planning Programs is created.

—The Health Training Improvement Act of 1970 which extends the allied health educational program for three years with aid to schools and students. Authorized appropriations total $308.5 million. The maximum yearly loan will be $1,500 and the maximum aggregate loan, $6,000, for any student. A forgiveness of up to 50% will be allowed if the student practices in a shortage area or for a nonprofit organization after graduation.

—The Developmental Disabilities Services and Facilities Construction Amendments of 1970 extending the mental retardation facilities construction program for three years and expanding it to include grants for planning, provision of services, and construction and operation of facilities for persons with developmental disabilities. Authorized appropriations total $295 million.





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Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.



Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

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Numerous investigators have remarked on the high degree of effectiveness of Lomotil in a variety of diarrheal disorders. Lomotil has given good to excellent relief of symptoms in many patients who had failed to respond to other measures.

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Patients prefer Lomotil for its convenience, its prompt control of diarrhea and its relief of cramping and urgency. Physicians specify Lomotil for its dependable action and its relative freedom from side effects when taken as directed.

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

953

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Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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Infectious Diseases

Introduction: The Need for Continuing Education

At the Frederick Memorial Hospital, a program recognizing the need for continuing education has been developed. This unique program seeks to afford intellectual stimulation to the medical community of Frederick.

ROBERT J. THOMAS, MD,
Department of Surgery
Frederick Memorial Hospital

The practice of medicine is a demanding intellectual taskmaster. The termination of formal training is but the beginning of a life-long program of continuing medical education. Nowhere is the need and urgency of such a continuing habit so accentuated as the medical environment of a small community. Hospital practice without house staff imposes a heavier physical burden on the practicing physician and denies him, at the same time, the intellectual stimulation afforded by the presence of house staff.

Faced with the reality of the situation, each location engineers its solution. At the Frederick Memorial Hospital, the program contrived is quite unique. Developed over many years of trial, it has succeeded in meeting the need for continuing education.

The heart of the program is a Postgraduate Education Committee which steers the entire program, with representation from all of the services. A system or subject is selected for staff review and study two years in advance. Topics are selected and speakers procured for a monthly meeting. This speaker from a medical center is payed an honorarium and the talk is transmitted over the MEDIC Network. It has become a tradition to precede the talk with a buffet luncheon.

The monthly talks begin in September of each year. During the preceding summer months, at each department meeting, films are programmed on the subject to be under study that year. This conditioning process prepares the staff for the year's topic.

The department meetings for the following ten months are organized to permit quarterly death conferences or perinatal mortality conferences, CPC's, and half-hour presentations by members of the staff on subjects centered on the main theme of the year, and pertinent to their department preoccupation.

The articles appearing in this issue are portions of talks presented by members of the staff in the course of this programming.

At the risk of sounding vain, our program seems to work for us. The aim of the program is the involvement of every member of the staff. The commodity that makes it possible is their enthusiasm and sympathy. The staff is particularly grateful to the administrator, Mr. Charles A. Markel. His dependable sympathy and support have helped us in many ways.

The purpose of this article is to discuss histoplasmosis as it is found in Maryland, Virginia and, more recently, the District of Columbia. I concern myself not only with a presentation of some scientific studies made in these areas, but attempt to acquaint you with some of the history of the disease that should be of interest to those who practice in the area covered by MEDIC. Some comments concerning diagnosis are included and, finally, a few general remarks are offered about the treatment of the disease.

Histoplasmosis

HENRY V. CHASE, MD
Department of Medicine
Frederick Memorial Hospital

Histoplasmosis, a highly infectious but noncontagious disease, is found throughout most of the world but it appears to be most prevalent in the United States. It is estimated that there are over 30 million persons in the United States who have had the disease and an average of 500,000 individuals are infected annually. Most of the basic research and clinical reports have been made on patients observed in this country.

Formerly, the endemic area was thought to be limited to the Mississippi River Basin but it is now known that the incidence is just as high in most of the area drained by the Potomac River. The endemic area extends into Maryland, Virginia, and parts of southern Pennsylvania.

Although the area in which we live is on the periphery of high endemicity, it was the center of many early, important, historical events.

The Discoverer

Samuel Taylor Darling, MD, discovered and described histoplasmosis at the very onset of his career. He was graduated from the College of Physicians and Surgeons of Maryland in 1903 with the honor medal for highest rank in a class of over 70. This school was one of seven in Baltimore at that time. After the Flexner report of 1910, his school merged with the University of Maryland School of Medicine.

After graduation, Darling spent two years as resident pathologist at the Baltimore City Hospitals. After competing his training, he joined the United States Public Health Service and requested duty in Panama where the canal was then being built.

Within four months after reaching the Canal Zone, he discovered the disease while doing routine autopsies on laborers who had died and were found to have had greatly enlarged or "Columbian" spleens. The first case report was published in 1906 by the AMA. Since the organisms appeared to be large, encapsulated plasmodium, engulfed by histocytes, he named the parasite "Histoplasma capsulata". His first patient was a young carpenter who was a native Martinque.

Two other fatal cases were found during the following year and, in 1907, Darling returned to his alma mater and reported on what he thought was the first series of a New World type of Kalaazar. His paper was given at Mercy Hospital in January 1907 and was published in the April 1907 issue of the *Maryland State Medical Journal.*

Darling returned to Panama where he was Director of Laboratories at the Ancon Hospital until 1915, but failed to discover another case of histoplasmosis there. He attributed this to the vast improvement in sanitary conditions achieved during the construction of the canal. During later years, Darling returned to Baltimore frequently and his family lived there and in Virginia while he traveled for long periods in Africa and Asia.

From 1917 to 1920, he and his family lived in Sao Paulo, Brazil, where he established and directed a school of hygiene under the Brazilian government and the Rockefeller Foundation.

Again, in 1920, he returned to Baltimore, but this time, he was seriously ill and was admitted to The Johns Hopkins Hospital. For several months he was under the close observation of Walter Dandy, MD, and finally, a benign brain tumor was surgically removed and he regained his health. During almost two years of convalescence, he worked at The Johns Hopkins School of Hygiene. During this time, he received an honorary degree of ScD from the University of Maryland.

His reputation as an international authority on malaria prompted the Rockefeller Foundation to ask him to establish a field laboratory at Leesburg, Georgia, for the investigation of malaria and malaria control. In 1925, he agreed to serve as a member of a Malaria Commission for the League of Nations and while traveling outside of Beirut, Lebanon, Darling was killed in an automobile accident. The Lebanese government erected a monument at the site of the accident to the memory of Dr. Darling and two other members of the commission who were also killed.

Although he considered himself a pathologist and is best known for his discovery of histoplasmosis, Darling is looked upon primarily as a medical zoologist. During a relatively short medical life span of 20 years, interrupted by prolonged and disabling illness, he managed to publish 103 articles and made significant original contributions to the field of medical parasitology, especially about malaria and hookworm disease.

Two decades after Darling's original report, the first case of histoplasmosis in America was observed in Minnesota. However, his well-known prophecy did not actually come true until 1938 when Hactel and Wright diagnosed the disease in a tavern keeper from Baltimore County, who was admitted to St. Joseph Hospital and died of disseminated disease. The diagnosis was established post-mortem by isolation of the fungus from a lymph node and blood.

First Epidemic

In 1949, one of the first epidemics of acute pulmonary histoplasmosis recognized in this country was studied at the University Hospital by Woodward. A farm family from Taneytown, Maryland contracted an acute pulmonary infection while cleaning manure out of their barn. The fungus was repeatedly cultured from specimens collected in and about the barn.

All of those infected by this epidemic recovered and their chest X-rays eventually showed numerous

calcifications. During World War II, many healthy, normal young men and women were rejected for service in the armed forces because these calcifications were thought to be evidence of healed miliary tuberculosis.

Prior to this, as pointed out by Comstock in a recent editorial, the association of histoplasmosis with pulmonary calcifications may well have had its beginning at the Hagerstown Tuberculosis Conference. In 1938, leading authorities in the field of tuberculosis met for a week in Hagerstown and discussed discrepancies in tuberculin testing and pulmonary calcifications. Tests in Williamson County, Tennessee, and Washington County, Maryland had established the fact that pulmonary calcifications were frequently found among persons who did not react to tuberculin. Palmer, a member of the conference, later showed by extensive skin testing surveys on student nurses, that infection with *Histoplasma capsulatum* was the most common cause of pulmonary calcifications in the United States.

Skin Tests

The use of the histoplasmin skin test has contributed much knowledge about the occurrence of the disease. Christie, in 1945, tested 181 children in an orphanage outside of Nashville and found 133, or 74%, to be positive to histoplasmin. He was the first to show that the disease frequently existed as a mild, asymptomatic infection and later caused the development of pulmonary calcifications in negative tuberculin reactors. Shortly thereafter, Palmer, as already mentioned, tested 10,000 student nurses and was able to map out the geographic distribution of histoplasmosis in the U. S. However, only 502 of those nurses tested were from Maryland and 31% were positive reactors. The number of nurses tested from Virginia and the District of Columbia was not given. At the same time, Emmons and his co-workers studied a rural community in Loudon County, Virginia, which is just across the Potomac River, and found that 83% of 476 residents had a positive histoplasmin skin reaction.

No other large scale skin test surveys were done in this area until 1957 when Edwards, Peeples, and Burger tested a group of high school students in Montgomery County, Maryland. The prevalence of histoplasmin sensitivity varied from 14% to 63% depending upon the location of the schools within the county. Seventy percent of life-time residents in the rural northwestern section bordering Frederick County were found to be positive. These data suggested that a study of adjacent Frederick County might be informative and, in the spring of 1961, second and sixth grade students of all the elementary schools in Frederick County were tested with histoplasmin. Of 1,924 students tested, 35% were found to be positive. Twenty-six percent of the second grade students and 42% of the sixth graders were positive. These data compare closely with those of Baybutt who carried out similar studies on 3,801 school children in Talbot County on the eastern shore. Thirty-nine percent were found to react to the antigen and, as expected, the percentage increased as the age of the student rose. Twenty-two percent of the first graders were positive and there was a gradual rise to 60% in the 12th grade students. Our studies in Maryland compare with those done in the well known, highly endemic areas bordering the Ohio and Mississippi river valleys. The studies done in Loudon County, Virginia compare closely with those done in Tennessee, while the results of the surveys done in Maryland are the same as those obtained in Ohio and Missouri. Thus, we feel that data has been accumulated to indicate that the Middle Atlantic states east of the Appalachians are highly endemic for histoplasmosis.

A more convenient skin test, the Tine histoplasmin test, is now available. It has many advantages over the usual Mantoux intracutaneous test, but a recent study comparing the two tests in Frederick County shows that the Tine test may fail to recognize a significantly large percent of those subjects who react positively to the histoplasmin Mantoux test. The results of a study that was done on 1,341 persons who were either patients at the Frederick Memorial Hospital or employees at Fort Detrick showed that 28% of those who were positive to the Mantoux failed to react to the Tine test. Approximately 4% gave a false positive result, that is, the Mantoux was negative, but the Tine was found to be positive. A recent report of the AMA by Froman gave more encouraging results but there was still a lack of agreement in 10.3% of those who were positive to the Mantoux and yet negative for the Tine test. The antigen impregnated on the four small prongs of the Tine test unit is relatively crude. The test would be more accurate if a refined antigen was used. There have been recent reports on studies designed to isolate the specific antigen that is related to histoplasmin sensitivity. Isolation of such an antigen has apparently been accomplished and there are indications that new and more precise tests will soon be available.

The fungus is bimorphic, that is, there is a yeast or parasitic phase seen in animals and a filamentous or saprophytic phase present in soil. Darling observed the parasitic or yeast form being engulfed by histocytes or monocytes and invading the reticuloendothelial system. He incorrectly surmised that the organism was a plasmodium. But in 1912, a Brazilian pathologist, DaRocha Lima, while studying Darling's original slides, correctly identified the organism as a fungus by comparing it to cryptococcus. Three decades later, DeMonbreun, a pathologist at the Nashville General Hospital, was able to artificially culture Histoplasma from a fatal case that had been diagnosed for the first time ante mortem.

Christie used a crude extract of DeMonbreun's culture in his first skin test survey in the orphanage.

Shortly thereafter, Chester Emmons, MD, of the National Institutes of Health, while searching for the fungus in man and animals both in Virginia and nearby Maryland, first showed that rats and mice could be naturally infected with the disease. Because of important public health implications, he began to test soil samples obtained in and about rat burrows. From December 1946 to December 1948, 387 soil samples from various farm sites in Loudon County, Virginia were cultured and, finally, two were found to be positive for Histoplasma. The two positive specimens were collected from a mound of earth at the entrance of a rat burrow which happened to be beneath a chicken house. At the time, he was unaware of the association of bird droppings with the presence of the fungus in soil. He was able not only to isolate H. capsulatum by culture but demonstrated the tuberculate spores in the soil, when examined directly under the microscope.

Isolating the Organism

It was not until 1957 that the true incidence of the disease in this area was appreciated. Emmons and Campbell collected over 50 proven cases of histoplasmosis that had occurred in Maryland, Virginia, and the District of Columbia and were able to isolate the organism from 22 premises in this area. In the fall of 1960, Emmons isolated the fungus from ten of ten specimens of soil collected in a small park in downtown Washington. This area was directly across from a large department store. On a windy day, many people were surely exposed to the park dust. Emmons was also able to collect positive soil specimens from another downtown Washington park, adjacent to the busy Union Train Station.

We have cultured the organism from a site in the Middletown Valley where a farmer contracted the disease while cleaning out an old abandoned silo. Attempts to find the fungus in various parks throughout the city of Frederick have been unsuccessful. Several years ago, after it was found that the fungus existed in downtown Washington, an attempt was made to isolate the organism in several large cities along the eastern seaboard. During this survey, Dr. Emmons and I collected specimens from various parks in Baltimore where it was known that starlings and grackles frequently roosted. Specimens were also collected from several downtown buildings and from the parks in Mt. Vernon Place. Over 100 specimens were taken but none were positive.

It is well known that the fungus is associated with the droppings of various birds, but the birds are not infected by the fungus and do not harbor the organism. A bird's temperature averages 105 F and this environment is probably incompatible with the growth of the fungus. However, it thrives in soil that has been mixed with bird droppings. Recently, the bat has been suspected as a possible vector in the spread of the disease. Being a mammal, its body temperature allows it to harbor the fungus. Since the original report in 1962 when the fungus was isolated from a bat captured in Panama, there have been numerous articles supporting the concept that the bat is closely associated with the peculiar micro distribution of the fungus in endemic areas. However, data from a recent report from Florida does not support this concept. Histoplasmosis is practically nonexistent in that state and there is a high incidence of the disease in bats that infest numerous caves in the north-central section.

The fungus has been isolated from feather pillows and this could conceivably be a source of infection in infants who have not been exposed to dust or soil contaminated by bird droppings.

Inhalation of spores or mycelial fragments usually causes a mild, benign and transient pulmonary infection which is rarely recognized and the diagnosis is usually made in retrospect. If the number of spores inhaled is large, an acute pneumonitis develops. Frequently, a diagnosis of viral pneumonia is made. Rarely in children and even more rarely in adults, the infection becomes widely disseminated with extensive invasion of the reticuloendothelial system. Frequently this type is seen in patients with a debilitating disease such as leukemia or lymphoma and in persons on large doses of steroids or other immunosuppressive therapy. A small number of primary pulmonary infections may progress into a chronic, cavitary type that is difficult to distinguish from pulmonary tuberculosis.

When the fungus is widely disseminated, various complications may develop and present as the major clinical picture, such as Addison's disease, acute pericarditis, meningitis, or endocarditis. Active disseminated disease and chronic pulmonary infection both require specific treatment or they are invariably fatal. Solitary or multiple ulcerations may occur in the oropharynx and in various parts of the intestinal tract. The iliocecal area is a favorite site and, at times, the granulomatous lesions are mistaken for carcinoma. A recent case observed here illustrates the point that a chronic anorectal fistula with recurrent abscess may rarely be due to histoplasmosis.

Here in Frederick County, a study is being conducted to correlate histoplasmosis with a peculiar form of chronic peripheral uveitis. The association of the condition with this particular fungus infection has been presumed, but not established, and it is hoped that the results of this excellent survey will give some of the answers to an unsettled and important problem.

Diagnosis

A high index of suspicion is vital in making a

diagnosis of this disease. A history of exposure to dust is a clue that usually requires detailed questioning by the physician. At times it is obvious, such as a recent cleaning of a chicken house or an abandoned silo, or a visit to a cave. But many times there is no known exposure to dust that may contain the spores of the fungus.

Physical examination is not helpful unless one finds a suggestive sign such as erythema nodosum or an unusual mucous membrane lesion which, on smear, biopsy, or culture may help to establish the diagnosis.

Chest X-rays are nonspecific—there are no pathognomonic signs. In acute, severe pulmonary infections there may be a miliary or diffuse nodular infiltration that resembles a typical pneumonia. Occasionally the patient looks well, has a mild cough, but may have extensive X-ray signs.

An attempt to culture the fungus in an acute pulmonary infection is rarely successful. However, when disseminated or chronic infection is suspected, an aggressive approach is indicated. Sputum is frequently cultured, but only in the chronic cavitary type is it found with any consistency. As in tuberculosis, bronchial washings and gastric washings should be obtained if necessary. Urine, stool, bone marrow, and blood are frequently productive sources for culture of the fungus. The marrow may be examined directly by routine as well as special stains. Scalene nodes and liver biopsy are other accessible sources of material for direct examination and culture. As mentioned, one should not overlook the opportunity to take a smear or scraping from a suspicious mucous membrane lesion. By using a Wright or Giemsa stain, the organism may be found.

Occasionally, the yeast phase in tissues is easily demonstrated on routine H & E stains but usually special silver stains are necessary. A control or known positive biopsy should be run simultaneously with each specimen, as these special stains require very precise technique.

H. capsulatum is probably the most difficult of the systemic fungi to grow. Growth takes longer and the fungus is most fastidious. Early subculture of suspicious colonies should be done frequently in order to avoid overgrowth by contaminants.

Culture of soil collected from a possible source of infection, many times, is helpful in confirming the diagnosis. This is a time-consuming procedure requiring about five weeks. The white mouse is exquisitely sensitive to the fungus and is used to isolate it from soil, as well as from clinical material. Ajello has shown that only one tuberculate spore is necessary to cause an infection in the albino mouse.

The type of media used is not as important as is an interested and experienced microbiologist who will take the necessary care to collect and prepare the specimens properly.

Serologic tests for histoplasmosis have many shortcomings and they are due, in part, to the crudeness of the antigens. Also, antibody response to acute fungus infections is generally slower than it is in bacterial infections and demonstration of the antigen is not as precise. Apparently, patients suffering from histoplasmosis may be immunologically responsive to all the antigens, to some of them, or to none. A lack of response does not exclude the diagnosis, especially when only a single specimen has been tested and when the clinical picture strongly suggests the disease.

Tests

Of the various tests available, the latex fixation and complement fixation tests are used most widely.

The latex fixation test is readily available in most laboratories and is easily performed. It becomes positive early in the course of an acute infection—as early as the 10th to 14th day after exposure. This is usually the time it takes for clinical symptoms to become manifest. In mild, primary cases, it is usually positive, but since the agglutinins or precipitins are transitory, the test is seldom positive in chronic, slowly progressive cases. False positive reactions detract somewhat from the utility of commercially available latex tests.

The complement fixation of CF test should be performed in conjunction with the latex fixation test. CF antibody response is usually observed after the 14th day in the course of the disease and elevated titres persist for several additional weeks or months. Then, in self-limited infections, rapidly decrease to residual levels of 1:8 or 1:16. These residual levels may remain unchanged for from three to five years or may become negative in as little as six months.

Both antigens, namely histoplasmin and the whole yeast phase antigen, should be used in the CF test to provide maximal diagnostic coverage. Serums from culturally confirmed cases of histoplasmosis may react to only one of these antigens. The whole yeast antigen is usually more reactive in acute cases while the histoplasmin titre rises in chronic, residual lesions with cavitation or fibrosis. In following a patient, persistent elevation of the histoplasmin antigen should alert one to the possibility of chronic infection.

Serologic tests have no diagnostic value in patients with a single pulmonary nodule that requires differentiation from carcinoma. It is highly presumptuous to establish a diagnosis of active histoplasmosis on CF titres of less than 1:32.

The histoplasmin skin test should be used with discrimination or not at all on persons who are subsequently to be serologically tested to establish the diagnosis of acute histoplasmosis. As with the tuberculin, it is frequently negative during the early acute phase and, if used in previous histoplasmin-positive patients, it will confuse the interpretation of

serologie titres. In patients who were previously negative to this antigen, stimulation by histoplasmin will not raise the titre signifieantly but, in a patient who has already been sensitized, there may be a rise in the CF titre to as high as 1:256 and the results of paired sera are misleading. One should always draw paired sera speeimens at least a week or two apart before applying the skin test.

Cross-reactions with blastomycosis and coccidiomyeosis are frequent and many times, in the initial sera specimen, the titre for the blastomyees antigen is higher than the histoplasmin or yeast phase antigen for histoplasmosis. This is usually elarified by paired sera as the titre of the eross-reacting antigen (in this ease blastomyces) falls, while there is a significant rise in the titre of the offending fungus (histoplasma). Coccidiomycosis is usually no problem as the cross-reaeting titre is usually lower and remains low. The titre of the blastomyces antigen is higher than either of the antigens for histoplasmosis in the initial specimen. As eaeh specimen is obtained, there is a fall in the cross-reacting antigen and a gradual rise in the titre of the antigens of the fungus that is the cause of the disease.

Treatment

Preventive treatment is of value and ineludes the use of masks or other proteetive apparatus when exposure to known hazardous dust is unavoidable. Before cleaning chieken houses, old atties, or abandoned silos, one should wet down the area while wearing a mask. A known area eontaminated by the fungus can be treated with 3% formalin as was done in Mason City, Iowa where, before treatment, 65% of soil specimens were positive for the fungus and one year after treatment, all specimens were negative.

The majority of patients with histoplasmosis require only symptomatic and supportive therapy, ineluding the majority of those with severe, aeute pulmonary disease. However, disseminated or chronie infections need speeifie treatment. We have seen severe, acute, bilateral pulmonary involvement reeover eompletely without specifie therapy. Whereas recently, a patient with diffuse miliary infiltration went on to develop widely disseminated disease several months after it appeared that the lungs had eleared almost entirely.

Sulfa therapy is effective against the organism both in vitro and in experimental animals. Christie uses triple sulfa in children with serious disease. In South America, Negroni reports that it is 50% effeetive when used in the treatment of the disease. However, most authorities who treat significant numbers of patients with deep mycotic infections report poor results with sulfa therapy.

A recent, careful cooperative study by the Veterans Administration and armed forees hospitals showed that a eombination of sulfa and amphotericin B was no more effeetive than amphoteriein alone in the treatment of ehronie eavitary histoplasmosis.

Amphotericin B, the first really effective broad spectrum antifungal agent for the treatment of systemie myeosis, was isolated in 1955 by Gold from Streptomyees nodosum recovered from a soil sample taken along the Orinoco River in Venezuela. Streptomycin and nystatin were originally isolated from other strains of Streptomyees.

Marketed under the trade name of *Fungizone*, the antibiotie is fungistatie and not fungieidal at elinically obtainable concentrations. It is effective only when given intravenously or intratheeally as it is poorly absorbed from the GI tract or from intramuscular sites.

Unpleasant side effeets invariably develop with its use but there is a wide individual variation as to the degree and frequeney of these reaetions. Chills, fever, nausea, vomiting, and anorexia occur to some degree in most patients. The severity of side effeets ean be modified by giving a small dose of steroids prior to the four- to six-hour infusion.

Although only a small amount of the drug is exereted through the kidney (roughly 5%), it causes serious renal toxieity—mainly reversible. But permanent parenehymal damage is frequently demonstrated by renal biopsy or at autopsy. Regular determinations of serum urea nitrogen and ereatinine are mandatory. Anemia and hypokalemia are frequent eomplications but they disappear after therapy.

Since the drug is used so infrequently in the average, general hospital, details of dosage need not be given but when one embarks on a course of treatment with this drug, he must be prepared for a long and arduous task, both on the part of the patient and the physician. The usual course of treatment for disseminated or cavitary pulmonary histoplasmosis is three months and relapse occasionally oceurs which requires treatment.

Bennett, at the NIH, has reeently shown that double dose alternate day therapy gives blood levels which are as good as those obtained with daily treatment. This halves the number of infusions, the time spent by both physieian and patient, the ineidence of thrombophlebitis of arm veins, and the occurrence of side effects.

Summary

The ineidence of histoplasmosis is as high in this area as in the midwest.

Many early historieal events assoeiated with the disease have taken plaee in Maryland and nearby Virginia. Since the diagnosis of the disease still depends on a high index of suspicion, it is appropriate, even after 63 years, to quote Darling's prophecy recorded in the Alumni Bulletin of the School of Physicians and Surgeons—"The disease is bound to appear in Baltimore some day. I hope it does not catch you napping."

Salmonella and shigella infections have presented the greatest problem in communicable diseases in Frederick County in the past three years. While no deaths have occurred, these diseases have been a major cause of illness.

Shigella and Salmonella Infections in Frederick County

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Two cases of typhoid fever have been reported in the city of Frederick during the past three years. One patient was a 66-year-old woman whose 74-year-old husband gave a history of typhoid fever many years before. Multiple cultures of the husband's stools showed typhoid organisms. There were many cross connections in the plumbing of the old house where the couple lived. No other cases of typhoid occurred in this area of the city.

The second case was a 13-year-old boy and occurred almost one year after the first. Extensive epidemiological investigation failed to reveal the source of his illness, but cross connections were also found in the house where he lived, which was in a different section of the city from that of the couple in the first case.

Both plumbing violations were corrected.

It is interesting to note that both patients were residents of the city of Frederick, which has a municipal water and sewerage system.

The treatment of the 74-year-old typhoid carrier was discussed with his physician. Because of the patient's age and cardiac disease, it was decided that no attempt should be made to eradicate the carrier state. In a recent study of the treatment of 60 typhoid carriers by Dinbar and his associates, it was found that ampicillin offered a good chance of success in patients without biliary disease if large doses and prolonged therapy are used. In biliary carriers with stones, the combined surgical-antibiotic method of treatment gave much better results than either therapeutic measures.

The U. S. Public Health Service has recently changed its recommendations for typhoid vaccine for overseas travel. The vaccine is no longer recommended if the traveler stays in the usual "tourist accommodations".

Causes of Salmonella

Most of the salmonella infections, other than typhoid fever, have occurred as sporadic infections for which no cause could be found. Two major outbreaks have occurred. In one outbreak, over 100 students and faculty members in a college became ill with gastroenteritis probably as the result of eating contaminated ship-rounds of beef. At the time of investigation, there was none of the beef available for examination. Salmonella St. Paul was isolated from the stools of four patients.

Three of eleven persons who lived in a rural house that had been converted to a three apartment building became ill. Salmonella typhimurium was isolated from the stools of these patients. The water supply came from a spring which was found to be heavily contaminated. Chlorination of the water supply eliminated the contamination and no further infections occurred.

The sources of salmonella infections are food, water, domestic animals (dogs particularly, and cats to a lesser extent), fowl, and turtles.

Chronic carriers of salmonella organisms other than typhoid are rare. Antibiotics have been found to prolong the excretion of salmonella and the clinical value of antibiotics in amelioration of symptoms of uncomplicated, Salmonella gastroenteritis is questionable. Antibiotics also favor the development of resistant strains, making these infections potentially more dangerous.

Shigella Incidence

The incidence of shigella as compared to salmonella infections has been interesting and puzzling. Table I shows that for each year since 1965, the number of salmonella cases has not varied very much. For the three years 1967 to 1969, however, the incidence of shigella infections was much greater than in 1966 and 1970. It is also interesting to note that all the cases of bacillary dysentery were caused by *Shigella sonnei*. In 1969, a waterborne outbreak of shigella dysentery accounted for some of the cases.

Table 1: Shigella and Salmonella Infections Frederick County 1966-1970

	Shigella	Salmonella
1966	**1**	**16**
1967	**16**	**8**
1968	**23**	**15**
1969	**38**	**13**
1970 (to October 1)	**2**	**11**

Between December 12, 1968 and January 12, 1969, 21 cases of *Shigella sonnei* occurred. There was no increased incidence of these infections in the rest of the state. An epidemiologic study of these cases demonstrated no common source, although there was evidence of transmission of the organism from one family member to another in different families.

In May and June, 1969, 54 of 114 residents in 26 dwellings of a housing development developed febrile gastroenteritis. *Shigella sonnei* was isolated from 9 of 17 patients in four households. Except for a common water supply, no factors could be found to account for the outbreak. The developer had not installed a chlorinator for the water supply even though he had been informed by letter he was required to do so. The plans he had submitted and which were approved by the Health Department included a chlorinator. The outbreak ceased promptly after a chlorinator was installed (as indicated in Figure 1).

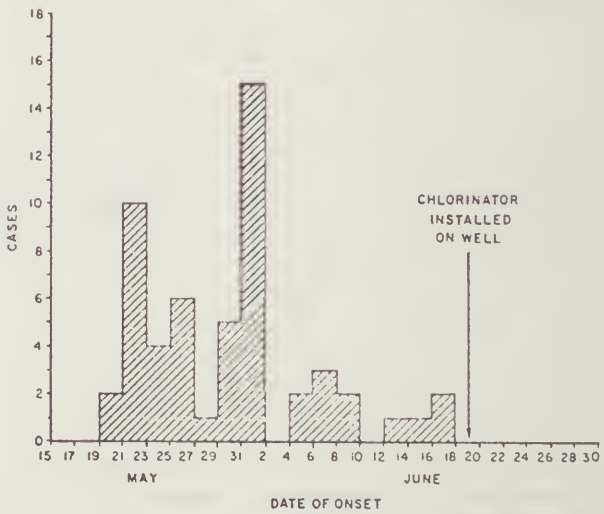


Figure 1: Febrile Gastroenteritis by Date of Onset in Frederick County, Maryland, May 15-June 30, 1969.

Most of the shigella infections in the United States in recent years have been caused by *Shigella sonnei* or *flexneri*. Infection with *Shigella dysenteriae* or *boydii* is rare in the United States and suggests foreign acquisition of the disease.

In the United States, shigellosis occurs principally in mental institutions, on Indian reservations, and in lower economic groups. Shigella infections are transmitted by food or water, flies, direct contact, and objects soiled with feces.

Ampicillin is the drug of choice in the treatment of shigellosis and a tetracycline is an alternative drug. Antibiotic therapy may not be essential in most cases since the disease is usually mild and self-limited.

Both salmonella and shigella infections continue to be Frederick County's major health problems. Both are puzzling and interesting diseases. Perhaps time and study will help us to eradicate them.

Q Fever

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A review of the cases of rickettsial disease experienced at the Frederick Memorial Hospital during the period of 1959 to 1969 was performed recently. The case records indicated that Rocky Mountain spotted fever was diagnosed in 13 cases and recovery was achieved in 12 of them. One patient died.

This experience demonstrated that no other rickettsial disease of man was diagnosed during that period. This negative finding seems quite unusual. Frederick County is a farm area in which milk production and cattle raising are dominant features of the economy. In the Milwaukee, Wisconsin milkshed, 73% of the cattle are infected with Q fever, though only 3.4% of humans in the area have complement fixation antibodies. Apparently, skin testing is more sensitive, since 98% of dairy workers react.

In September 1969, the *New York Times* carried an article on biological weapons. It pointed out that potential agents for biological warfare are chosen from four kinds of microorganisms: bacterial diseases, such as plague and anthrax; viral diseases, such as yellow fever and encephalitis; anticrop fungal disease such as rice blast and potato blight; and rickettsial disease such as Q fever and Rocky Mountain spotted fever.

Fort Detrick, in Frederick, Maryland, is America's center for research and development of biological warfare agents. Detrick personnel have played a key role in developing at least four strains of known disease for military use. These diseases are anthrax, tularemia, psittacosis, and Q fever.

A close look at Q fever might provide a valuable

resource for physicians practicing in this geographic area.

For many years, Q fever was classified in the genus *Rickettsia.* About 25 years ago, a separate genus, *Coxiella,* was created for Q fever, since it presented so many differences from the genus *Rickettsia*: ie, it is filterable, very resistant to physical and chemical agents; it does not evoke agglutinins against Proteus X strains; it does not produce a cutaneous rash; it does not elicit a "toxic" reaction in experimental animals; it is not inhibited by the antibiotic thiocymetin; and it does not require an arthropod vector to maintain itself successfully in nature.

Recognizing Q Fever

Historically, Q fever was first recognized as an entity in Brisbane, Australia about 35 years ago. Slaughterhouse workers manifesting a febrile illness of epidemic proportion were found to have the offending microorganism in their blood and urine.

An obligate, intracellular, parasitic microorganism, C. burneti produces in humans an acute systemic illness. Ushered in with sudden onset, it is accompanied by malaise, chills, fever, myalgia, and most characteristically, severe headache.

C. burneti was found to occur in almost all domestic and wild animals, birds, insects, flies, ticks, lice and mites. Domestic cattle, sheep and goats have been incriminated as the reservoir of human Q fever. Curiously, in these animals reservoirs, the infection is not apparent. Apparently healthy animals shed enormous numbers of coxiella in the milk, urine, feces, and placenta.

Cases of Q fever have been traced to contaminated clothing, to dusty straw, and to soil contaminated with animal droppings. The available evidence suggests that the organisms gain entry to the human through the conjunctivae, by the ingestion of raw milk or, in the majority of cases, by inhalation.

Q Fever Epidemics

Two properties possessed by C. burneti are of importance in the establishing of Q fever epidemics. The first factor is the extreme resistance of the organism to the hardships of the environment. This enables the organism to endure for months on objects such as clothing, farm implements, trucks, or simply in the dirt and dust of the countryside. The second factor is the small size of the infectious dose. The infectious dose for man is one organism and with larger doses, each organism acts independently in the initiation of infection.

When first recognized as an entity, Q fever was little suspected of being capable of causing an epidemic or having a world-wide distribution. Time proved otherwise. World War II set the stage for epidemics of generous proportions in German occupation troops in Italy, the Ukraine, the Crimea, Bulgaria, and Greece. British troops experienced outbreaks of the disease in Greece and Italy.

In the United States, outbreaks have occurred in Southern California, Texas, and Chicago.

Since World War II, epidemics have been recognized in Italy, Germany, Switzerland, USSR, the Balkans: some 51 countries on five continents. When the disease breaks out, the epidemics are quite large. For example, in the California epidemic, more than 50,000 people were found to be infected.

Following an incubation period of 18 to 21 days. the disease manifests with high fever, chills, severe frontal headache, general malaise, anorexia, and myalgia. Severe retro-orbital or eye pain is a common complaint. Patients manifest a relative bradycardia, hepatomegaly, splenomegaly, and pneumonia. There is suprisingly little in the way of physical findings on examination of the chest. The disease is rarely fatal, and complications are rare. The disease may assume a chronic form in persons over 40 years of age. In contrast to rickettsial disease, hepatitis and subacute endocarditis are encountered in Q fever.

The disease should be suspected in any patient who has been in direct or indirect contact with livestock. The diagnosis may be established in isolation of the organism from the blood or by a significant rise in specific antibodies. Serologic methods are the procedures of choice. Agglutinins tests appear more sensitive than complement fixation tests. Agglutinins appear early in the illness and are demonstrable in about 50% of patients within the first week. The percentage of positives rises to 100% within four weeks after onset. In contrast, complement fixation antibody is encountered only rarely during the first week of illness, but rises to about 90% by the end of the fourth week.

Treatment

The tetracycline group of drugs has been found to be effective in relieving the disease symptoms if administered in the first three or four days of the illness. Chloramphenicol is not as successful as the tetracyclines. These drugs are not as effective in the treatment of Q fever as they are in the treatment of rickettsial diseases.

Person-to-person infection with C. burneti has been reported, but appears to be an unusual occurrence.

Vaccines against Q fever have been prepared and appear to offer protection. A high incidence of local reaction to the vaccine diminishes its usefulness. Vaccination of high risk individuals might be a profitable pursuit. The vaccination of cattle does not appear economically feasible.

Located as we are in Frederick, knowledge of this disorder may clarify an otherwise puzzling clinical problem.

The biology of the lymphocyte has become one of the most exciting stories in contemporary medicine. For most of us, having been out of medical school for some years, the small lymphocyte is a cell in the "white cell" series, about which we were taught little. From differential white cell counts we recognized that the lymphocyte accounted for between one fourth to one third of the normal adult white cell differential count. We were aware that this cell type was seen frequently in association with chronic processes in tissue sections.

THE LYMPHOCYTE

ROBERT J. FURIE, MD
Department of Pathology
Frederick Memorial Hospital

We were also always aware that the lymphocyte was a cellular component of blood, the major cell type of the lymph nodes, spleen, and Peyer's patches; and was distributed diffusely throughout the bone marrow and intestinal mucosa. The cell was described as about eight micra in diameter, endowed

with very little cytoplasm, devoid of an apparatus for protein synthesis, and neither phagocytic nor chemotactic. It was also said to lack the mechanism and ability for cell division. Not a very strong list of attributes, it would seem.

The Lymphocyte and Immunity

The lymphocyte, we now learn, is virtually linked to immunity.

Immunity is an everyday word, ordinarily applied to the elaborate set of responses by which the body defends itself against invading microorganisms or foreign tissues. Antibody production in response to antigen stimulus has been known since the late 19th century. The production of immunity is classically considered to be the synthesis of gamma globulin antibodies, capable of uniting with antigens, to render them noninjurious either by precipitation or by some other means of inactivation.

However, it is now appreciated that this description is an oversimplification. Immunity comprises more than the formation of circulating (humoral) gamma globulin antibodies.

Three patterns of immunity are recognized: (1) the production of circulating gamma globulin antibodies which result in immediate immune reactions; (2) poorly understood antibodies as seen in hay fever; and (3) cell-based immunity or sensitivity known as delayed immunity responsible for such reactions as the tuberculin reaction.

The involvement of the small lymphocyte in these immune processes is a fascinating story. Once felt to be a homogeneous cell population, lymphocytes are now known to be anatomically and functionally heterogenous. These undistinguished cells actually represent cells which look alike but have a different heritage and destiny.

The cell type involved in the immune reaction is the lymphocyte. The manner in which this is achieved is better understood through a review of what happens when a small lymphocyte is challenged. This small lymphocyte, which lacked the power to divide and which was manifestly inert, springs to life. These small cells enlarge and begin to exhibit reticular chromatin. Prominent nucleoli then appear and large amounts of intensely basophilic vacuolated cytoplasm is evident. These enlarged, transformed cells replicate their DNA and go on to mitosis. These "transformed" lymphocytes may change into the morphology of a plasma cell which produces circulating (humoral) antibody; or they may mature into the small lymphocyte characteristic of the cell type seen in delayed hypersensitivity, the fixed type of tissue reaction of which the tuberculin reaction is prototype.

Not all lymphocytes are capable of displaying the tissue type of immune reaction. Those lymphocytes which are competent to perform this function are thought to be derived from the thymus gland. Those lymphocytes which transform into globulin-producing plasma cells (which manufacture circulating antibodies) are derived from other central lymphoid organs such as the intestinal lymph nodes of man.

The Transformation of Lymphocytes

There are several "triggers" for the transformation of lymphocytes just described. They transform (1) when they meet an antigen to which they have been previously exposed and sensitized; (2) when they encounter tissues from another individual with whom they are not tissue compatible; (3) when these lymphocytes are treated with various antisera produced against their surface constituents; and (4) when they are exposed to certain nonspecific agents such as bacterial toxins, phytohemagglutinins, etc.

After each stimulus, these small, dormant lymphocytes are capable of arousing an inflammatory response in the tissues in which they are located, and to which they have been previously indifferent. From mechanisms within the cells, which are triggered by the encounters with the stimuli, these transformed lymphocytes release substances into the surrounding medium which may have a number of effects.

These effects may be to: (1) kill previously intact sister cells; (2) inhibit the migration of macrophages; (3) call forth other leucocytes; (4) cause vascular permeability; and (5) transfer to other previously inert lymphocytes the capacity to become similarly transformed after further encounter with suitable antigens.

Such transformed cells are, therefore, fully equipped to do battle with unwelcomed cells when they are introduced by the transplantation surgeon, or are the result of somatic mutation as in the case of cancer cells, or are recognized as foreign because of damage inflicted by acute inflammation. In the process, this system—apparently designed for surveillance and elimination of undesired pathogens or cells—can also produce factors which injure normal cells in the vicinity of the conflict.

After the need for the transformed lymphocytes has terminated, it would be ideal if some regulatory mechanism would stop the proliferation and activity of these lymphocytes. In those cases where this "shut-off" mechanism does not operate effectively, chronic inflammatory processes ensue, which might be typified by rheumatoid arthritis, graft rejection, and autoimmunity. It is of some interest that those agents (such as cortisone, chloroquine, and some immunosuppressive drugs) which inhibit the response of normal lymphocytes to "transforming" agents not only suppress delayed hypersensitivity but inhibit the mechanisms of surveillance and rejection.

Obviously, this is but the beginning. Much more will be learned about this cell type—the lymphocyte.

Postoperative Wound Infections

ROBERT J. THOMAS, MD
Department of Surgery
Frederick Memorial Hospital

In the history of surgery, a major period of significant advance took place when an understanding of the role of bacteria in wound infections led to remedial practices. This period of success was achieved by the employment of strict practices aimed at reducing the opportunity for infection, from within or from without.

It might be said that this era of surgical success, in large part due to the control of postoperative infection, continued until the days of the introduction of antibiotics. Overconfident of the effectiveness of antibiotics, surgeons became more and more careless in the practice of the simple principles upon which a generation of surgical success had been built.

Aseptic technique, a time-proven method, was abridged. The preparation of the patient, the cleansing of the operative area, the details which had made success possible in the past, were abridged, bypassed, and ignored. The use of adequate masks was disparaged. Reliance on "cold" solutions for sterilization was introduced in preference to steam autoclaving. Cross-contamination of dressing carts and wounds was tolerated. Wounds were exposed to the air without appropriate dressings. Surgeons, nurses, and technicians were reluctant to scrub their hands and forearms adequately. Punctured gloves were not changed.

The rise of antibiotic "prophylaxis" led to a sense of false security which, coupled with false reasoning, led to overconfidence. The very drugs the patient needed to receive in treatment of the postoperative infection were useless. The offending organisms had long since become resistant to those antibiotics. The hospital environment created resistant strains of microorganisms through the abusive employment of prophylactic antibiotics.

Truly, then, what are the facts? What information is valid for the adequate treatment of patients?

While the opportunities for postoperative infection to gain a foothold are many, it is the current consensus that several general, broad truths can be expressed.

Sources of Infection

Obviously, postoperative infections can arise from so-called exogenous sources, ie, the surgical team or operating personnel, the patient's skin and the equipment, instruments, and materials used in the operating room.

It is equally obvious that there may be endogenous sources of these postoperative infections, ie, skin, patient's upper or lower respiratory tract, gastrointestinal tract, regional lympathics, and the blood stream.

Extensive studies have been carried out in an attempt to identify the major problem sources of microorganisms in postoperative infection. While

just about every source can cause postoperative infection, the experience in the studies indicate that direct contact from either exogenous or endogenous sources tops the list. Environment air and endogenous bacteremic sites are not a frequent source. One fact stands out consistently—people seem to be the basis for most sources of contamination.

The message inherent in the conclusions of these studies is that people who follow careful, reasonable practices will prevent a great many postoperative infections.

Since the hospital expects bacterial contamination as a by-product of treating sepsis, every effort should be made to keep the contamination to a minimum through the practices of cleanliness, isolation, and design.

The operating room and its immediate environment must receive the most detailed attention to diminish the intensity of possible contamination. While it is inevitable that patients going to the operating room are grossly contaminated, every conceivable practice must be analyzed to reduce that level of contamination. Too often expediency is the guiding light with the price of postoperative sepsis the result.

Reducing Contamination

Methods of sterilization must receive conscious review and, where possible, sterilization by steam must be the method of choice.

Those responsible for making and enforcing the rules in a surgical department must recognize the validity of the concept that most postoperative infections result from contact contamination. Most of this problem revolves about people who comprise the surgical team who, either by contact or aerosol, infect the patient. Inadequate scrubbing, punctured gloves, and infections of the skin (apparent or inapparent) lead to the postoperative sepsis.

Aseptic technique must be established and maintained strictly in the operating room. No breaks in technique should be tolerated.

Persons who are known to have infections with staphylococci must be excluded from the operating room, the recovery room, and from the intensive care areas.

It goes without saying that all unnecessary persons must be excluded from the operating room. Persons not trained adequately in aseptic technique must not be allowed to work in the operating room.

A constant vigil must be maintained so that the instruments and supplies used in the operating room are effectively sterilized.

Materials that are particularly difficult to sterilize, such as ointments, powders, etc, must receive special and continued attention.

Worthy of special note are those instruments such as cystoscopes, resectoscopes, endoscopes, etc, which cannot be sterilized with steam. The methods available to render them sterile are so uncertain that a constant vigilance is needed to insure the efficiency of the methods.

All street clothes should be removed and operating-room attire put on before entering the operating room. Obviously, those surgeons who parade about the hospital in their "scrub" suits should be brought to account with admonition. They should be instructed to change clothes before re-entering the operating suite. No exceptions should be allowed. The wearing of proper masks, worn properly, should be routine and mandatory.

Team Effort Needed

All personnel involved in the surgical team effort should be required to scrub their hands and forearms preoperatively. Meticulous attention to this time-honored, reliable practice should be given with no deviation from established rules being permitted. Re-scrubbing between cases must be insisted upon. Punctured gloves must be changed immediately.

The operative area must be prepared and draped in acceptable fashion. The skin surface must be prepared properly, allowing the skilled person time for the procedure. Shaving should not be done in the operating room. Diligent scrubbing, liberal use of soap and water, and the chemical disinfection of the skin must receive as much deliberate and devoted attention as the washing of the surgeon's hands. The draping of the operative area should be done purposively, carefully, and expertly.

The patient may be a source of the contamination. This is particularly true in operations of the lung and gastrointestinal tract associated with the transection of a hollow viscus. Every effort should be made to isolate the contamination through surgical technique, rather than to rely on antibiotic therapy.

The stocking of the dressing cart and the changing of dressings afford a good opportunity for cross-infection unless measures are enforced to prevent their occurrence. No detail should be allowed to escape effective remedy.

The indiscriminate use of antibiotics has already been referred to on several occasions. The advice against such practice is founded on solid evidence. Similarly, the prophylactic use of antibiotics, except in rare and specific circumstances, has no merit and should be avoided.

Lastly, housekeeping is part of the team effort. No detail of design or dusting is unimportant. Not only the intent to reduce contamination must be wholesome: the methods employed must be completely reviewed for their efficiency.

There is no room for complacency. If postoperative infections are to be maintained at an acceptable minimum, everyone involved must play a conscious alert role.

It has been established that about 40% of patients with fever of unknown origin will eventually develop features which will permit a diagnosis to be made. About one half of these problem cases will recover without having had a diagnosis established. Ten percent of this group of patients will continue to be febrile, without a diagnosis being reached.

Exploratory Laparotomy in Fever of Unknown Origin

REX R. MARTIN, MD
Department of Medicine
Frederick Memorial Hospital

An analysis of the experience of others in the management of fever of obscure origin is a profitable, practical exercise. By study of their data, a productive course of action may be fabricated.

Yale Study

About 15 years ago, at Yale, 100 consecutive patients with the problem of fever of obscure etiology were studied. The following table shows the diagnostic categories into which the patients were grouped.

A. Infections—34

TBC—11
Liver and Biliary Tract—7
Endocarditis—5
Abdominal Abscess—4
Pyelonephritis—3
Brucellosis—1
GC Arthritis—1
Malaria—1
Cirrhosis with Bacteremia—1

B. Hypersensitivity States—4

Granulomatous Hepatitis—2
Erythema Multiforme—1
Drug Fever—1

C. Facitious Fever—3

D. Undiagnosed—7

E. New Growths—19

Carcinomatosis—7
Localized Tumor—2
Lymphoma, Leukemia—8
Unclassified—2

F. Collagen Disease—15

Rheumatic Fever—6
SLE—5
Cranial Arteritis—2
Unclassified—2

G. Miscellaneous Disease—16

Pulmonary Embolism—3
Benign Nonspecific Pericarditis—2
Sarcoidosis—2
Periodic Disease—5
Weber-Christian—1
Thyroiditis—1
Myelofibrosis—1
Ruptured Spleen—1

One third of these patients died. Of those who recovered, 38% were judged to have done so only because the exact diagnosis was made. Appropriate, specific therapy hinged on the correct diagnosis. This experience underlines the need to exhaust every reasonable means to establish the correct diagnosis in such patients.

An important point may be learned from an analysis of the autopsy diagnosis in this series of 100 patients.

Causes of FUO Discovered at Autopsy

Monocytic Leukemia—2
Miliary TBC—1
Liver Abscess—1
Subphrenic Abscess—1
Ascending Cholangitis—1
Bacterial Endocarditis—1
Multiple Pulmonary Emboli—1

The point to be gained is that serious infection may be most difficult to diagnose and thus delay treatment or result in improper treatment.

Frequently, in managing a patient with fever of obscure cause, there comes a time when, despite one's best diagnostic efforts, the etiology of the patient's fever remains obscure. At that point, a difficult decision must be made. Should the patient be treated

blindly? Or should the final step be taken—exploratory laparotomy? Since there are divergent opinions on the value of abdominal exploration in these cases, particularly in those instances in which there is little or no evidence pointing to intra-abdominal disease, a review of the experience of others has merit.

Mayo Clinic Report

A report from the Mayo Clinic, involving an analysis of 70 such patients, appears to be the largest series to date. In their groups, 30 of the 70 patients had no subjective or objective indication of intra-abdominal disease.

Mayo Clinic Experience

Malignant Disease	**21**
Specific Infection	**15**
Indeterminate Disease	**14**
Miscellaneous	**6**
Nothing Found	**14**
	70

From this tabulation, it is apparent that positive information was established in 80% of the cases. In only 20% was nothing found. A definite diagnosis was established in 60% of the cases. The morbidity and mortality due to the operative procedures were said to be negligible.

The Johns Hopkins Series

In the fall of 1969, a group at The Johns Hopkins Hospital reported a series of 28 patients with fever of unknown origin who were subjected to abdominal exploratory laparotomy. These patients were studied intensively for at least three weeks prior to operations. In all instances, the studies failed to establish a precise diagnosis.

Exploratory laparotomies were performed on 28 patients. As a result of the surgical procedure, the cause of the fever was established in 16 out of the 28 patients, or 57%. This tabulation further reveals that in all but one instance, the cause of the fever could be treated. And, in fact, the fever subsided with appropriate treatment.

Findings at Laparotomy

Malignant Disease—3
Infection—6
Collagen Vascular Disease—4
Sarcoid—2
Regional Enteritis—1

There were no postoperative deaths and no significant complications occurred as a result of the operations.

It is of some interest to pursue the causes of fever that were established later in those cases in which no diagnosis was possible at the time of abdominal exploration.

Subsequent Course of Negative Laparotomies

Diagnosis Never Established—7
Diagnosis Established—5
Brucellosis—1
Reticulum Cell Sarcoma—Knee—1
Stone—Common Bile Duct—1
Maxillary Sinusitis—1
Factitious Fever—1

Of 12 cases not diagnosed at laparotomy, seven remained undiagnosed, even after the passage of considerable time.

Exploratory laparotomy should not be performed until all other pertinent diagnostic studies have been completed. The diagnostic approach must include not only various laboratory, X-ray, and other special procedures but also, and above all else, a searching clinical observation during which the patient is thoughtfully requestioned and reexamined.

Fever of Unknown Origin

Fever alone is no cause for haste. The art of clinical management of fever of unknown origin is knowing when to terminate such observation. Against haste is the fact that some 20% of such patients eventually recover spontaneously without any specific treatment. And, we are all much too familiar with the sad experience of observing adverse clinical course following a surgical procedure. In general, the less objective clinical evidence there is of some intra-abdominal abnormality, the longer should be the period of observation. Physical and psychiatric strain on the patient must be considered. From the physical standpoint, the key question is whether any of the organ systems are being importantly affected in a deleterious manner. Clearly, progressive alterations call for immediate decisions.

At the time of operation, a midline incision is used. The liver should be biopsied whether it is manifestly diseased or not. All organs should be closely examined. If any abnormalities are found, the involved tissue should be removed for histologic examination. It is desirable to divide the specimen for histologic and microbiologic study.

In the diagnosis of fever of unknown origin, after a period of meticulous and unrewarding study and observation, an exploratory laparotomy should be considered. In cases where abdominal symptoms are present, exploratory laparotomy is likely to produce information of specific therapeutic value. When no evidence of intra-abdominal disease manifests, one should prolong the period of observation and search the abdomen only if there is progressive deterioration of the patient's status.

Fever of unknown origin continues to present a challenging problem to the clinician. When fever is the primary evidence of illness over a period of time exceeding three weeks, a sound approach to diagnosis is imperative.



MINUTES OF THE BUSINESS SESSION

Semiannual Session, House of Delegates
(270th Meeting)
Medical and Chirurgical Faculty of the State of Maryland
Friday, September 11, 1970
Hotel Hershey, Hershey, Pennsylvania

The 270th meeting of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:40 AM, Friday, September 11, 1970, at the Hotel Hershey, Hershey, Pa., the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance: An asterisk indicates an alternate delegate.

Doctors: Manning W. Alden, Council; *Faye W. Allen, Anne Arundel County; Robert G. Angle, Montgomery County; Charles Bagley, III, Wicomico County; Timothy D. Baker, Baltimore City; George S. Banning, Jr., Prince George's County; Richard D. Bauer, Past President; Emidio A. Bianco, Baltimore County; M. McKendree Boyer, Past President; Henry A. Briele, Council; D. Delmas Caples, Baltimore County; Douglas G. Carroll, Baltimore City; Katharine A. Chapman, Montgomery County; John T. Chissell, Council; John N. Classen, Baltimore City; Archie R. Cohen, Washington County; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Richard Y. Dalrymple, Council; Worth B. Daniels, Jr., Baltimore City; H. Vincent Davis, Cecil County; Melvin B. Davis, Baltimore County; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; John M. Dennis, Council; J. Sheldon Eastland, Past President; Wolcott L. Etienne, Council; George G. Finney, Jr., Baltimore City; Vincent J. Fiocco, Carroll County; Elliott R. Fishel, Baltimore City; Russell S. Fisher, Council; Gina M. Glick, Allegany; Robert B. Goldstein, Council; George H. Greenstein, Baltimore City; Paul F. Guerin, Council; *J. Roy Guyther, St. Mary's County; William B. Hagan, Council; Louis E. Harmon, Baltimore City; John C. Harvey, Council; Philip W. Heuman, Harford County; Claude D. Hill, Baltimore City; *Charles Earl Hill, Baltimore County; *John C. Hyle, Baltimore County; J. Parran Jarboe, Council; Ferd E. Kadan, Baltimore County; William H. Kammer, Baltimore County; Seruch T. Kimble, Council; *John M. Krager, Baltimore County; *Justinas Kudirka, Howard County; Henry P. Laughlin, Council; Herbert H. Leighton, Garrett County; Charles H. Ligon, Council; Elmer G. Linhardt, Board of Medical Examiners; Charles B. Marek, Baltimore City; Francis C. Mayle, Jr., Montgomery County; Karl F. Mech, Council; B. Martin Middleton, Council; Donald W. Mintzer, Baltimore City; Andrew C. Mitchell, Wicomico County; Marvin I. Mones, Montgomery County; Frederick E. Musser, Prince George's County; Chas. F. O'Donnell, Council; *J. Allan Offen, Montgomery County; Hilary T. O'Herlihy, Anne Arundel County; William A. Pillsbury, Council; *Frank E. Poole, Wicomico County; Thaddeus E. Prout, Baltimore City; *Belden R. Reap, Montgomery County; J. Morris Reese, Past President; Thomas Reid, Frederick County; Antonio M. Rivera, Anne Arundel County; Martin A. Robbins, Baltimore City; Donald J. Roop, Council; Edwin Ruzicka, Talbot County; Peter Santucci, Montgomery County; John F. Schaefer, Council; Emanuel A. Schimunek, Council; *John O. Sharrett, Baltimore City; Margaret L. Sherrard, Baltimore County; Arthur G. Siwinski, Council; Gordon M. Smith, Mont-

gomery County; *John R. Smith, Queen Anne's County; Roland T. Smoot, Baltimore City; Aaron C. Sollod, Baltimore City; William G. Speed, III, Council; George R. Spence, Montgomery County; Martin E. Strobel, Baltimore County; Robert J. Thomas, Council; Chris P. Tountas, Baltimore City; Francis J. Townsend, Jr., Worcester County; John B. Umhau, Montgomery County; *Baltasar B. Velez, Baltimore County; Thomas E. Van Metre, Jr., Baltimore City; Hugh W. Ward, Calvert County; Chas. E. Wright, Frederick County; *N. Louise Young, Baltimore City; Raymond M. Yow, Council.

Present also were staff personnel.

INVOCATION

Karl F. Mech, MD, Treasurer of the Faculty, delivered the invocation.

ANNOUNCEMENTS

The President made announcements dealing with the conduct of business at the session.

INTRODUCTION OF NEW MEMBERS

The President introduced the following new members of the House of Delegates:

Robert B. Goldstein, MD, Baltimore City (Council)
Charles H. Ligon, MD, Sandy Spring, Second Vice-President (Council)
Emanuel A. Schimunek, MD, Baltimore City, First Vice-President (Council)
Daniel I. Welliver, MD, Westminster, Third Vice-President (Council)

MINUTES OF ANNUAL SESSION

The minutes of the House of Delegates of the April 1, 1970 and April 3, 1970 sessions, having been distributed to all members and having been approved by the Executive Committee, were presented to the House for information.

EMERITUS MEMBERSHIP

On motion of the Council Chairman, the following members who had received the recommendation of their respective societies and the Council, were elected to Emeritus Membership in the Faculty:

Irene B. Barrett, MD, now of Littleton, Colo. (Montgomery County)
Robert B. Mitchell, MD, Baltimore City

REPORT OF THE COUNCIL

Dr. Alden, Council Chairman, presented the following report to the House of Delegates in connection with referral from the Annual Session. The report was received for information.

The Medicare Newsletter quoted at the House of Delegates Session on Friday, April 3, 1970, does not place an "arbitrary restriction" on the number of visits a physician may make on a patient, but reads as follows:

"Please be sure to include current medical diagnosis. Medicare regulations stipulate that payments be made only where there is clear medical necessity for the services being performed. As a general guide when requesting payments for visits in excess of four a month, be sure that the diagnosis given reflects the acute condition being treated."

1971 SEMIANNUAL HOUSE SESSION

Dr. Alden, Council Chairman, on behalf of the Council, offered a motion to hold the Semiannual House Session in Puerto Rico, where the scientific programs are to be held.

After debate, this motion was lost.

1969 AUDIT REPORT

Karl F. Mech, MD, Treasurer, presented the Auditor's statement for the year 1969. There being no objection, the auditor's statement was approved.

INFORMATION 1969 COMMITTEE REPORTS

The following 1969 Committee Reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions.

Report of the Delegates to the American Medical Association—Robert L. Campbell, MD, J. Sheldon Eastland, MD, Russell S. Fisher, MD, December 1969 Clinical Meeting
Executive Director—Mr. John Sargeant
Library and History Committee and Finney Fund Committee—Paul F. Guerin, MD, and D. C. W. Finney, MD
Curator—Edwin David Weinberg, MD
Medical Annals—Leslie E. Daugherty, MD
Committee on Program and Arrangements—DeWitt E. DeLawter, MD
Committee on Contractual Arrangements—J. Howard Franz, MD, *Chairman*
Editorial Board, *Maryland State Medical Journal*—C. Thomas Flotte, MD
Committee on Emotional Health—Exall L. Kimbro, MD
Finance Committee—Karl F. Mech, MD
Maryland Medical Service, Board of Trustees—J. Sheldon Eastland, MD, *Chairman*
Med-Chi Insurance Trust—Paul F. Guerin, MD
Medical Emergency Disaster Service Committee—No committee appointed 1969/70
Committee on Postgraduate Education, Preventive Medicine and Public Health—John Whitridge, MD
Membership Committee—No committee appointed 1969/70—Committee abolished September 5, 1969
Public Relations Committee—Richard A. Young, MD
Mediation Committee—Lewis P. Gundry, MD
Secretary—William A. Pillsbury, MD
Medicolegal Committee—Robert W. Johnson, 3rd, MD
Board of Medical Examiners—Elmer G. Linhardt, MD, Secretary/Treasurer
Medical Economics Committee—W. Kenneth Mansfield, MD
Legislative Committee—B. Martin Middleton, MD
Liaison Committee—John Kehoe, MD
Medicine and Religion Committee—George M. Simons, MD
Occupational and Environmental Health—Harold P. Biehl, MD
Professional Medical Services Committee—George H. Greenstein, MD
Policy and Planning Committee—Arthur T. Keefe, Jr., MD

Woman's Auxiliary to the Medical and Chirurgical Faculty—Mrs. Wallace H. Sadowsky

SPECIAL COMMITTEE ON MEDIC NETWORK

Thaddeus E. Prout, MD, on behalf of the Special Committee on the MEDIC Network, offered the following motion for consideration of the House which, after discussion, was adopted as follows:

Resolved, That the MEDIC Network be and it hereby is, declared an integral part of the effort of the Faculty in continuing medical education; and

Resolved, That notice be given to all delegates at least 60 days before the annual session of the Faculty to be held in 1971 of a proposal to impose an assessment on all active members in the amount of $5 per year for an indefinite period under the provisions of the Bylaws of the Faculty in Article III, Section 6; and

Resolved, That a study be made to obtain additional financing from other sources which may be applied to the total effort of the Faculty in the field of continuing medical education.

HOSPITAL ASSESSMENT DEFEATED

Dr. Prout, on behalf of the Special Committee on the MEDIC Network, offered the following motion for consideration of the House which, after debate, was DEFEATED:

Resolved, That member MEDIC Hospitals be assessed by a modest annual charge, based on bed capacity, as follows:

NUMBER OF BEDS	ANNUAL ASSESSMENT
Less than—99	$ 50
100-199	100
200-299	200
300-399	300
400-499	400
500 plus	500

SUBCOMMITTEE NAME CHANGE

Dr. Prout offered, on behalf of the Subcommittee, that the MEDIC Subcommittee name be changed to Subcommittee on Continuing Medical Education. This being an administrative matter, the House endorsed this proposal.

REFERENCE COMMITTEE REPORT RESOLUTION 1S/70 WITHDRAWN

Dr. Leighton, on behalf of the Reference Committee, requested permission for the Baltimore County Medical Association to withdraw Resolution 1S/70. There being no objection, the resolution was withdrawn.

RESOLUTION 2S/70 ADOPTED

Dr. Leighton, on behalf of the Reference Committee, moved the adoption of Resolution 2S/70 which, after debate, was adopted as follows:

Subject: Instructing the Professional Medical Services Committee to Establish Valid Data on a Minimum Three-Year Basis Concerning Current Charges for Physicians' Services Based on Usual, Customary and Reasonable Fees

Whereas, It is the established policy of the Medical and Chirurgical Faculty of the State of Maryland that reimbursement to physicians be on the basis of Usual, Customary and Reasonable fees, and

Whereas, This policy is frustrated by the unavailability of accurate information regarding such fees to third party agents, such as insurance carriers, federal and state government reimbursement parties, and

Whereas, These organizations will continue to use outdated fee schedules and other inaccurate and inadequate data unless the medical profession can supply them with valid data for physicians' services; now, therefore, be it

Resolved, That the House of Delegates instruct the Professional Medical Services Committee to establish valid data concerning current charges for physicians' services based on Usual, Customary and Reasonable fees charged private patients throughout the State of Maryland; and be it further

Resolved, That this Committee be required to review, revise and present to the Society such data at intervals not to exceed every three years.

RESOLUTION 3S/70 REFERRED TO LEGISLATIVE COMMITTEE

Dr. Leighton, on behalf of the Reference Committee, moved that Resolution 3S/70 be referred to the Legislative Committee, and, after debate, it was so referred:

Subject: Investigation and Possible Action Regarding Legislation to Assess Nonmembers of Professional Organizations Payment for Services Provided by Professional Organizations

Whereas, Part of the responsibilities of the Medical and Chirurgical Faculty of Maryland is disciplining all physicians in Maryland; handling of complaints against physicians; determining the propriety of fees charged by physicians; determining ethical policies to be followed by physicians; determining the adequacy of quantity and quality of care provided by physicians; conducting studies affecting the health of the people of Maryland, such as drug abuse, multiphasic screening, preschool hearing and vision testing, immunization projects; developing codes of cooperation with allied and related professional groups; and developing legislative activities related to medicine and health; and

Whereas, These responsibilities also apply to other professional associations such as the Maryland State Dental Association, the Maryland State Pharmaceutical Association, the Maryland State Nurses Association, the Maryland Licensed Practical Nurses Association, the Maryland State Bar Association, to mention only a few; and

Whereas, The provision of these services and activities, which indirectly benefit the public, should not be borne solely by those professionals who hold membership in the Professional Organizations providing these services; now, therefore, be it

Resolved, That the Legislative Committee of the Medical and Chirurgical Faculty of the State of Maryland

contact those professional groups involved to ascertain their interest in developing legislation that would require the appropriate professional licensing boards to collect from nonmember professionals sums to cover the discharge of these responsibilities in lieu of membership dues paid to the professional organization involved; and be it further

Resolved, That the Legislative Committee, if it ascertains that cooperation is forthcoming, draft suitable legislation to accomplish this purpose, with 50% of the receipts to be paid to the state professional association of the discipline involved and the balance paid to the local association where the professional concerned maintains his office or in which he practices, after suitable deduction of administrative expenses involved in such collection activities.

PRESS RELEASE ON ALLEGED MEDICAID SURPLUS

Manning W. Alden, MD, Council Chairman, offered the following motion to the House which, after discussion, was adopted as follows:

That the House of Delegates authorize a press release to educate the public with respect to the doctor's role in the existence of any surplus that may exist in the Medicaid program.

ANNOUNCEMENTS

Several announcements were made by various House members and the President.

There being no further business, the House adjourned *sine die* at 11:30 AM.

WILLIAM A. PILLSBURY, MD, SECRETARY

REPORTS

To The House of Delegates, Semiannual Meeting, Friday, September 11, 1970

PRELIMINARY REPORT OF AD HOC COMMITTEE TO INVESTIGATE ALL FACETS OF MEDIC

Mr. President and Members of the House of Delegates:

An initial meeting of this Ad Hoc Committee was held on Wednesday, June 24, 1970. At this meeting, the charge to the Committee, which reads

> "that the President of the Faculty appoint an Ad Hoc Committee to investigate all facets of the MEDIC Network and render a report to the House of Delegates at the 1970 Semiannual Meeting"

was considered. As appointed by the Faculty President, three of the Committee members were pro MEDIC and three against.

Two questions were posed to the Committee: (1) Is the MEDIC network of sufficient value to continue it? (2) If so, where should financial support be obtained?

Following the posing of these two questions it was concluded that MEDIC should be continued, improved in any way possible, and the number of replays increased. The Committee considered alternative methods of financial support. In other areas of the country where similar programs are in operation, assessments are made on participating hospitals and in other areas it is financed through the Regional Medical Program. It was noted that the MEDIC Network is used by hospitals for emergency as well as regular meetings, by Civil Defense, the School Health Council, etc. It was felt the hospitals would receive more benefit from the network if it were used by nurses and other paramedical groups.

It was also concluded that the network must be operated on a more permanent basis than currently, which is from year to year.

The following recommendation is, therefore, made to the House of Delegates:

That the members of the Ad Hoc Committee, present at the meeting on June 24, 1970, constituting a majority, are unanimously in favor of continuing the MEDIC Network; that the network is considered an integral part of the Faculty's effort in continuing medical education; that there be an annual assessment on active Faculty members, placed on the dues bill, for continuing medical education, including MEDIC as well as other educational programs of the Faculty (an assessment of $5 per year per active member of the Faculty would adequately support MEDIC); and that this assessment need not preclude attempts to obtain financial support from other sources, which can be applied to the total effort of continuing medical education.

A more detailed report will be submitted by August 15, 1970, after further figures have been obtained and recommendations for obtaining the necessary financing established.

Respectfully submitted,

JOHN WHITRIDGE, JR., MD, *Chairman*
*ROBERT T. ADKINS, MD
*D. THOMAS CRAWFORD, MD
ROBERT W. FARR, MD
JOHN C. HYLE, MD
THADDEUS E. PROUT, MD
R. LANE WROTH, MD

* Absent from meeting

STATISTICAL REPORT ON MEDIC AS OF JUNE 1970

	MEDIC ATTENDANCE FIGURES				
	1965-66	1966-67	1967-68	1968-69	1969-70
Number of Locations	13-24	24-27	27-38	38-45*	45
Programs Presented**	22	33	33	32	33
Total Attendance	1972	2219	2671	2920	3849
Average Attendance Per Program	89	67	80	91	116

* Includes six private offices
** Friday lecture series only

MEDIC EXPENSE

	HOSPITAL RENTAL OF EQUIPMENT	MED-CHI TRANSMISSION COST	HEALTH DEPT. ADMINISTRATIVE
Monthly	$1,076.85	$1,227.00	$1,250.00
Annual	$12,922.20	$14,724.00	$15,000.00

* * * * * * * * * * * *

COPY

REGIONAL MEDICAL PROGRAM FOR MARYLAND

Heart Disease-Cancer-Stroke

July 6, 1970

Frederick J. Heldrich, Jr., MD
Medical Subcommittee
Medical and Chirurgical Faculty
State Department of Health
301 West Preston Street
Baltimore, Maryland 21201

Dear Fred:

In a letter to you dated April 10, 1970, Dr. Peeples attached a copy of a letter sent to all of the 38 participating institutions in MEDIC and indicated that he would apprise you of forthcoming results.

As of July 1, 1970, we have had only 16 replies. The consensus is that attendance by physicians at MEDIC has been disappointingly poor. Some attributed this to the inconvenient hour that the program is presented. Most of the replies stated that the subject matter was good and that the physicians who attended found it scientific, informative, and up-to-date. Several hospitals commented that these presentations are being profitably used in graduate nurse teaching.

A general feeling is that, in a hospital, a Director of Medical Education or someone in a similar role must give continuous imaginative attention to MEDIC type programs to make them successful. Some expressed the opinion that the funds being used for MEDIC may be more effectively used in live television transmission or TV taping for distribution throughout the counties.

I regret that we were unable to get a greater response to our inquiry. However, I believe that the information we did receive represents a cross section of the views of most institutions to the MEDIC program.

Sincerely,

(SGD) ED

Edward Davens, MD
Coordinator

FINAL REPORT OF AD HOC COMMITTEE TO INVESTIGATE ALL FACETS OF MEDIC

AUGUST 15, 1970

Mr. President and Members of the House of Delegates:

As set forth in the preliminary report of this Committee on July 1, 1970, the following recommendation was made regarding the continuation of the MEDIC Network:

That the members of the Ad Hoc Committee, present at the meeting on June 24, 1970, constituting a majority, are unanimously in favor of continuing the MEDIC Network; that the network is considered an integral part of the Faculty's effort in continuing medical education; that there be an annual assessment on active Faculty members, placed on the dues bill, for continuing medical education, including MEDIC as well as other educational programs of the Faculty (an assessment of $5 per year per active member of the Faculty would adequately support MEDIC); and that this assessment need not preclude attempts to obtain financial support from other sources, which can be applied to the total effort on continuing medical education.

MEDIC has been funded by the Faculty through May 1971 and plans for the programs have been completed. It is the consensus of the Committee that MEDIC is one of the best efforts the Faculty has made in the area of continuing medical education and that it deserves Faculty support both philosophically and financially. It is felt that MEDIC is most successful in those hospitals where a physician has demonstrated his personal interest and has done his best to make it possible for local physicians to participate.

A second recommendation is made by this Committee:

That member MEDIC hospitals be assessed a modest annual charge based on bed capacity.

This recommendation was made by physicians who come from MEDIC hospitals. A suggested assessment that will apply to each MEDIC hospital is attached. The formula used to establish this assessment would be applied to any hospital joining at any time. The Faculty would continue to fund that portion of the MEDIC expense that is not covered by the proposed assessment. This assessment would be in addition to the cost for equipment rental which is presently paid by each member hospital.

The Preliminary Report of July 1, 1970, includes MEDIC attendance figures and MEDIC expense. Attached to the current report is a summary of the votes of the member hospitals regarding the assessment to be paid by hospitals in the MEDIC Network.

As a result of this study, the following resolutions are submitted for action by the House of Delegates:

1. **Resolved, That the MEDIC Network be, and it hereby is, declared an integral part of the effort of the Faculty in continuing medical education; and**

   Resolved, That notice be given to all Delegates at least sixty days before the Annual session of the Faculty to be held in 1971 of a proposal to impose an assessment on all active members in the amount of $5.00 per year for an indefinite period under the provisions of the Bylaws of the Faculty in Article III, Section 6; and

   Resolved, That a study be made to obtain additional financing from other sources which may be applied to the total effort of the Faculty in the field of continuing medical education.

2. **Resolved, That member MEDIC hospitals be assessed by a modest annual charge, based on bed capacity, as follows:**

NUMBER OF BEDS	ANNUAL ASSESSMENT
Less than 99	$50
100-199	100
200-299	200
300-399	300
400-499	400
500 plus	500

Respectfully submitted,

JOHN WHITRIDGE, JR., MD, *Chairman*
*ROBERT T. ADKINS, MD
D. THOMAS CRAWFORD, MD
ROBERT W. FARR, MD
JOHN C. HYLE, MD
THADDEUS E. PROUT, MD
R. LANE WROTH, MD

** Abstained from voting on this report as was unable to attend committee meeting due to illness.*

SUMMARY OF VOTES REGARDING MEDIC FROM MEMBER HOSPITALS*

ANNUAL ASSESSMENT

HOSPITAL	NUMBER OF BEDS	ANNUAL ASSESSMENT	FOR	AGAINST
1. Anne Arundel General	165	$100		
2. Baltimore County General	93	50	x	
3. Bon Secours	254	200	x	
4. Calvert County	67	50	x	
5. Carroll County General	124	100	x	
6. Church Home	297	200	x	
7. Cumberland Memorial	300	300		
8. Easton Memorial	156	100	x	
9. Eugene Leland Memorial	76	50		
10. Frederick Memorial	197	100	x	
11. Good Samaritan	244	200	x	
12. Greater Baltimore Medical Center	400	400	x	
13. Harford Memorial	186	100	x	
14. Kent & Queen Anne's	80	50	x	
15. Keswick	205	200		x
16. Lutheran	240	200		x
17. Edward W. McCready Memorial	36	50	x	
18. Maryland General	486	400		x
19. Mercy	334	300	x	
20. Montgomery General	54	50	x	
21. North Charles General	151	100		x
22. Peninsula General	332	300		x
23. Physicians Memorial	53	50	x	
24. Provident	125	100		
25. Sacred Heart**	247	200	x	
26. St. Agnes	414	400		
27. St. Joseph	346	300		

28. St. Mary's	75	50		
29. Sinai	488	400		x
30. Union Hospital of Cecil County	111	100		
31. Union Memorial	414	400	x	
32. Veterans Administration-Loch Raven	291	200		
33. Washington County	371	300		

** Replies have not been received from several MEDIC Representatives due to lack of time. It is expected this summary will be completed by the meeting of the House of Delegates in September.*
*** This affirmative vote is made only if a single assessment is made; eg, either assess the individual physician through the Med-Chi or assess the participating hospital, but not both.*

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Reference Committee met on Thursday, July 30, 1970, at 8 AM in the Faculty building to discuss the three resolutions introduced for consideration by the House of Delegates.

As is customary, all members of the Faculty were notified by postal card on July 22 of the resolutions to be considered. All Delegates and Component Society officers received complete copies of the resolutions mailed under date of July 23.

In accordance with Robert's Rules of Order (Revised), the Reference Committee's motions will be submitted on the resolution itself and the action taken will be on the resolution itself and not on the report.

Resolution 1S/70 was withdrawn by the Baltimore County Medical Association and, therefore, no action is required on this resolution.

Resolution 2S/70

Submitted on: July 16, 1970

Introduced by: Professional Medical Services Committee

Subject: Instructing the Professional Medical Services Committee to Establish Valid Data on a Minimum Three-Year Basis Concerning Current Charges for Physicians' Services Based on Usual, Customary and Reasonable Fees

Whereas, It is the established policy of the Medical and Chirurgical Faculty of the State of Maryland that reimbursement to physicians be on the basis of Usual, Customary and Reasonable fees, and

Whereas, This policy is frustrated by the unavailability of accurate information regarding such fees to third party agents, such as insurance carriers, federal and state government reimbursement parties, and

Whereas, These organizations will continue to use outdated fee schedules and other inaccurate and inadequate data unless the medical profession can supply them with valid data for physicians' services; now, therefore, be it

Resolved, That the House of Delegates instruct the Professional Medical Services Committee to establish valid data concerning current charges for physicians' services based on Usual, Customary and Reasonable fees charged private patients throughout the State of Maryland; and be it further

Resolved, That this Committee be required to review, revise and present to the Society such data at intervals not to exceed every three years.

Faculty policy was established by the House of Delegates at the Semiannual Session in 1965 and at the Semiannual Session in 1966. In four different resolutions adopted by the House of Delegates, it went on record as favoring payment to physicians for professional services on the basis of "Usual, Customary and Reasonable Fees," (for hospitalized medical care patients; Workmen's Compensation cases; all recipients of services under Medicaid; and also urging Blue Shield to establish a new plan to provide for payment of fees on this basis, with this new plan supplementing "to the greatest extent possible" all other plans with fixed fee schedules).

The sponsors of this resolution have emphasized that this resolution does not alter or modify Faculty policy as outlined above.

As is indicated in the Whereas portion of this resolution, third party payors have considerable difficulty in determining what a physician's Usual, Customary and Reasonable fee is. As a result, there is a tendency to use outdated schedules referring to them as "the latest information available".

This subject was discussed on a national level at the AMA House of Delegates session in June, in Chicago. At that time, the AMA House adopted a resolution that contained the following information:

Resolved, That state medical associations be urged to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice . . .

It is to be emphasized that the collection of "data" by the Professional Medical Services Committee would not constitute a "fee schedule," and that every effort would be made to emphasize and reemphasize that physicians should charge and be paid on the basis of their "Usual, Customary and Reasonable" fee.

Passage of this resolution merely implies the collecting of data concerning "Usual, Customary and Reasonable Fees" as of this time. With this understanding, the Reference Committee *recommends that Resolution 2S/70 be adopted.*

Resolution 3S/70

Submitted on: July 17, 1970

Introduced by: Wicomico County Medical Society

Subject: Investigation and Possible Action Regarding Legislation to Assess Nonmembers of Professional Organizations Payment For Services Provided by Professional Organizations

Whereas, Part of the responsibilities of the Medical and Chirurgical Faculty of Maryland is disciplining all physicians in Maryland; handling of complaints against physicians; determining the propriety of fees charged by physicians; determining ethical policies to be followed by physicians; determining the adequacy of quantity and quality of care provided by physicians; conducting studies affecting the health of the people of Maryland, such as drug abuse, multiphasic screening, preschool hearing and vision testing, immunization projects; developing codes of cooperation with allied and related professional groups; and developing legislative activities related to medicine and health; and

Whereas, These responsibilities also apply to other professional associations such as the Maryland State Dental Association; the Maryland State Pharmaceutical Association; the Maryland State Nurses Association; the Maryland Licensed Practical Nurses Association; the Maryland State Bar Association, to mention only a few; and

Whereas, The provision of these services and activities, which indirectly benefit the public, should not be borne solely by those professionals who hold membership in the Professional Organizations providing these services; now, therefore, be it

Resolved, That the Legislative Committee of the Medical and Chirurgical Faculty of the State of Maryland contact those professional groups involved to ascertain their interest in developing legislation that would require the appropriate professional licensing boards to collect from nonmember professionals sums to cover the discharge of these responsibilities in lieu of membership dues paid to the professional organization involved; and be it further

Resolved, That the Legislative Committee, if it ascertains that cooperation is forthcoming, draft suitable legislation to accomplish this purpose, with 50% of the receipts to be paid to the state professional association of the discipline involved and the balance paid to the local association where the professional concerned maintains his office or in which he practices, after suitable deduction of administrative expenses involved in such collection activities.

This resolution includes a partial listing of those services and activities of the Faculty from which all physicians in the State of Maryland benefit. While the wording may be difficult to understand, it does nothing more than to instruct the Legislative Committee of the Faculty to consult with other professional groups (Dental Association, Nurses Association, Pharmaceutical Association and other health or health-related professionals) to ascertain their feelings in this regard.

If such groups are in accord with this principle, it would be explored further with the licensure boards concerned, as well as with the Secretary of Health and Mental Hygiene, under whose jurisdiction all such licensure boards function.

If accord is gained after these consultations, the Legislative Committee would then develop legislation that would accomplish these objectives. Presumably, such other professional groups would support such legislation if their governing bodies approved of the principle.

The Reference Committee concurs in the exploration of this proposal, though it is obvious that voluntary broad membership participation or even compulsory Med-Chi membership would be preferable and easier to enforce than compulsory billing of nonmembers.

Any policy decision would have to be approved by either the Council or the House of Delegates when that stage of the discussion is reached. The Reference Committee, therefore, recommends that Resolution 3S/70 be referred to the Legislative Committee for a study of this and alternate approaches to this problem.

The Reference Committee would again like to make a plea to individual members of the Faculty to attend the open hearings on resolutions and to express their viewpoints. The custom in the past has been that only a small percentage of the total membership is on hand to hear the discussion that takes place. It would be of great assistance to the committee to hear as many views as possible on resolutions that involve Faculty policy.

Respectfully submitted,

HERBERT H. LEIGHTON, MD, Oakland, *Chairman*
MELVIN B. DAVIS, MD, Dundalk
MARVIN I. MONES, MD, Silver Spring
WILLIAM H. MOSBERG, MD, Baltimore
RAYMOND M. YOW, MD, Salisbury



Semiannual Meeting—1970



Left: At the podium, Faculty President Dr. Henry A. Briele conducts the business session of the Semiannual Meeting held on Friday, September 11 in Hershey, Pennsylvania. Faculty VIPs also participating were (from left): John Sargeant, Executive Director; Dr. William A. Pillsbury, Secretary; and William J. Evans, Parliamentarian.



Right: No kidding! Golf can be hard work. Relaxing between rounds of the Faculty's golf tournament are (from left): Dr. U. G. Bourne, Jr., and Dr. Louis E. Harmon.



Left: It was easy to forget business and concentrate on pleasure at Saturday evening's cocktail party. Dr. Karl F. Mech (second from left) and Mrs. Mech (seated) seem to be enjoying the conversation and festivities as Mrs. Genevieve Ritchie of the Faculty staff looks on. Behind Dr. Mech are Dr. Archie Cohen and Dr. Joseph Taler.

your medical faculty at work

by John Sargeant

Executive Director

The Executive Committee met on Thursday, October 29, 1970, and took the following actions:

1. Approved the minutes of the House of Delegates session held in Hershey, Pa., Friday, September 11, 1970.
2. Authorized appointment of William A. Pillsbury, MD, Timonium, to be the Faculty representative on the Maryland Hospital Education and Research Foundation.
3. Authorized the Executive Director to further explore with the Maryland Chapter of the American Academy of Pediatrics the possibility of providing administrative and financial services for that organization on a cost basis. A report will be made to the Executive Committee on this matter.
4. Received word that a problem between the Judiciary and one of the Faculty's components was resolved satisfactorily.
5. Designated various nominees to Maryland Hospital Service, Inc. (Blue Cross) for appointment to Physician's Review Committees, to replace members whose terms are expiring. The lists from which the nominees were selected had been solicited from medical staffs at all general hospitals in the state.
6. Took formal action authorizing sale by auction of duplicate copies of books and out-of-scope copies of books from the library holdings (does not apply to rare books). This had been discussed and approved at previous Council sessions, but no formal motion had been adopted.
7. Agreed to defer legal action in connection with the use of the term "Chiropractic Physician" until this matter could be further explored.
8. Referred the recommendation from the "Blue Ribbon Committee" named by the Secretary of Health and Mental Hygiene in connection with the Salmonella outbreak in Baltimore, to the Nursing Home Liaison Subcommittee for implementation and report to the Council.
9. Referred to the same subcommittee for investigation and report a question posed by the statewide Health Facilities Association of Maryland about the use of medical directors to provide medical care, along with other duties, to all nursing-home patients.
10. Declined to provide the detailed information requested by the Finance Committe of Baltimore City Medical Society about the charges made by the Faculty for services provided that group. The details requested included: salaries of Faculty employees and a percentage of the time that such employees devoted to Baltimore City Medical Society activity. The same data that has been provided in recent years will be provided this year, with an assessment as to how these costs were reached.

The Council met on Thursday, October 29, 1970, in special session to discuss various federal and state activities in connection with delivery of health care services. Invited to join this special session was the entire Board of the Maryland Blue Shield Plan, Inc. After a lengthy discussion and debate, the Council took the following actions:

1. Directed the staff to prepare and to mail to all members a summary of the material already received by Council members, together with an explanatory covering letter.
2. Authorized the appointment of a Special Committee to investigate and to make recommendations to the Council for mechanisms which would best serve the public in the delivery of health care.



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of the State of Maryland

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Health Outlay: $300 A Person

Total health spending will average out to more than $300 for every man, woman, and child in the United States in 1970.

And hospital services will account for almost one third of the outlay.

An analysis of Consumer Price Index tables indicates that hospital costs have climbed faster than any other health service since the end of World War II.

Health care services, in turn, have increased faster than any other type of personal expense.

From 1945 through the first half of 1970, the cost of medical care has tripled, according to CPI data.

At the same time, the cost of all items in the market basket has doubled.

The nation's health care bill for the fiscal year ending June 1969 according to government figures totaled $60.3 billion, up from $48.2 billion just two years earlier.

The major increase was a 34% rise in hospital costs for the two years.

Last year these costs were up 13%. During the first half of 1970 they were up 6.2% and they had climbed nearly 700% since 1945.

Over the same 25 years, total insurance benefits from health insurance companies increased over 2,400%.

There are also more Americans receiving insurance benefits.

Last year 175 million persons were covered by private hospital expense insurance.

Back in 1945, some 32 million Americans had this form of protection, with 11 million covered by insurance companies.

Two reasons for the increase in insurance protection are the more frequent utilization being made of hospitals, and rising hospital costs.

While inpatient costs now average $81.66 a day, American Hospital Association studies point to this increase to $119.50 by 1973; and other estimates show that this will go much higher.

These increases have been attributed mainly to the higher salaries now being paid hospital employees as well as the increase in the number of these employees to care for an individual patient.

Other factors are the introduction of expensive equipment, and Medicare, which increased the demand for hospital beds, according to medical authorities.

Health Insurance News

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Attending Annual Meeting of the Medical and Chirurgical Faculty
All requests subject to confirmation



A Service of the Tuberculosis Association of Maryland

tuberculosis

Skeletal Tuberculosis

Skeletal tuberculosis occurs in approximately 1% of all patients with tuberculosis. Even if diagnosis is made after skeletal TB is moderately advanced, good joint function oftentimes can be expected from drug treatment alone.

Like pulmonary tuberculosis, skeletal tuberculosis has markedly decreased. In fact, it has become so uncommon that clinicians have become unaccustomed to think about it, even in patients with a previous history of tuberculosis or exposure to it.

Oftentimes diagnosis is delayed for many years. This is unfortunate since it leads to intractable bone and joint damage resulting in a marked loss of function. Therefore, a review of skeletal tuberculosis appears to be in order.

Due largely to modern effective chemotherapy, skeletal TB has been practically eliminated in children. So the discussion which follows deals primarily with adult disease.

Causes of Skeletal TB

Most skeletal TB probably results from the blood transport of tubercle bacilli from a focus of tuberculosis in an area or organ such as the lung, early in the course of the initial infection. In some instances though, the bacilli may be transported through the lymphatic system. One study suggests that most Pott's disease results from lymphatic dissemination of bacilli to the spine. Skeletal involvement may be the only manifestation of systemic disease.

The basic lesion is almost always a combination of osteomyelitis and arthritis. Invasion of the joint space may be either direct, via the blood stream or indirect from lesions in epiphyseal bone eroding into the joint space.

Initially, an inflammatory reaction develops in the synovium which, in turn, provokes granulation tissue. An effusion develops in which fibrin may precipitate, forming the so-called rice bodies. This pannus of granulation tissue then begins to erode and destroy cartilage and eventually cancellous bone. Ultimately, it leads to progressive demineralization and caseation necrosis.

TB infection does not produce the proteolytic enzymes which destroy cartilage so extensively and so abruptly in pyogenic arthritis. In skeletal TB, cartilage is destroyed peripherally at first. Joint space may be preserved for a considerable time.

In far advanced disease, para-osseous abscesses (the so-called cold abscesses) usually develop eventually, and these abscesses involve joint tissue.

Ultimately, erosion with sinus-tract formation may develop.

The healing process in bone and lung are similar. Fibrous tissue forms; usually it causes fibrous and possibly osseous ankylosis.

Clinical Aspects

In adults, skeletal TB usually occurs in the joints most subject to trauma. One study of 230 cases

Paul T. Davidson, MD, Isaac Horowitz, MD, The American Journal of Medicine, *January 1970, Vol. 48.*

revealed that over 70% of the lesions occurred in the spinal column, hip, knee, or sacroiliac joints.

However, any bone in the body can be involved. For instance, TB of the ribs occurs in approximately 5% of all cases of bone and joint TB. In fact, it is the most common inflammatory process involving the ribs. In older patients it may be seen in unusual locations, such as sternoclavicular joints.

Any monoarticular arthritis, particularly with a destructive lesion, is suspect. Patients with multiple osteolytic lesions should always alert the clinician to possible multiple skeletal involvement or even widespread dissemination of TB in the bone.

Early Diagnosis

If skeletal TB is properly diagnosed and treated early enough, good joint function will result.

TB should always be considered in patients who complain of skeletal pain, as pain is the most common complaint. There may be joint swelling and limitation of motion. A "cold" abscess is another clue.

The purified protein derivative tuberculin skin test remains one of the most valuable diagnostic tools and should be a routine part of the evaluation of any destructive arthritis or bone lesion, particularly spinal or monoarticular arthritis.

Recovery of bacilli in smear and culture of joint fluid or "cold" abscess aspirates confirms diagnosis. If necessary, a biopsy specimen of tissue should be obtained for examination and culture, preferably at an early date. A pathology report of granulation tissue with caseation necrosis compatible with tuberculosis is sufficient indication to begin therapy.

Good roentgenograms are invaluable in helping to establish the diagnosis and to follow the progress of the disease during therapy. Early lesions are easily missed since soft tissue swelling may be the only abnormality. Later, in long bones, small localized areas of osteoporosis occur subchondrally, often associated with a surrounding ring of sclerosis. Subsequently, varying degrees of cortical and cartilage destruction take place which in months or years can result in complete destruction of the joint space.

Changes in the spine are first noted as a slight narrowing of the intervertebral space. Later the adjacent vertebral bodies develop destructive lesions with eventual collapse and formation of varying degrees of scoliosis and kyphosis often referred to as gibbus formation.

The differential diagnosis of skeletal tuberculosis should include sarcoid arthritis and pyogenic arthritis caused by bacteria and fungi.

The so-called atypical mycobacterial infections have been implicated as causes of bone and joint disease in a number of reports. Clinically there is little to differentiate this infection from TB, although a case simulating rheumatoid arthritis has been reported. Atypical mycobacteria are frequently resistant to the usual antituberculosis drugs.

Neoplasms in bone can mimic tuberculosis. Often such lesions are metastatic from tumors of the breast, lung, or prostate. Finding the primary lesion helps to establish the etiology of the bone lesion. Since bone lesions caused by tumor are much more common than tuberculosis, the latter diagnosis is more likely to be overlooked, resulting in unnecessary delay and risk in treating a completely curable disease.

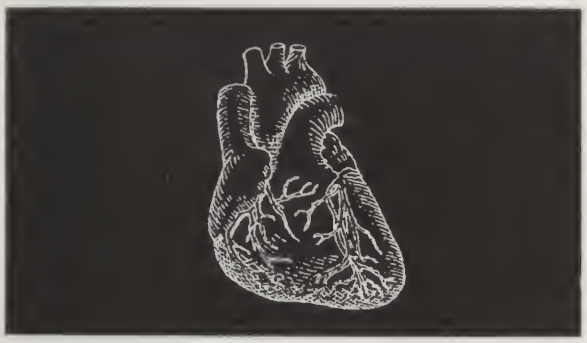
Treatment

Since the advent of chemotherapy, surgery is much less often necessary and much safer than before. Skeletal tuberculosis of the spine when associated with considerable destruction warrants surgical fusion because of the chance of collapse with paraplegia.

With effective chemotherapy, however, surgical intervention is only rarely indicated and should be reserved to prevent deformity, to improve function, and to arrest disease that has not responded to drugs. If diagnosis is made when the disease is in its early stages or even when it is moderately advanced, good joint function can be expected to result with drug treatment alone.

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MIRIAM L. COHEN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

The Work Evaluation Unit of the Heart Association of Maryland

DONALD H. DEMBO, MD
Chief Cardiologist and Head
Division of Cardiology
Maryland General Hospital
Baltimore

More than ten million Americans suffer with serious diseases of the heart and circulation. Twenty percent of all patients with coronary heart disease are in the 30 to 44 year age group, the prime of life. The standard recommendation to patients with heart disease has often been to discontinue working entirely, or to limit activity to light work. These vague work prescriptions have been impractical and unrealistic since industry is seldom able to assign employment without specific guide lines.

Long medical experience has shown that work appropriate to cardiac status results in less harm than inactivity itself which may be psychologically and socioeconomically disastrous for the family and for the community. The worker's fear of the effect his work will have on his heart, and his employer's fear that he will not be able to do his work satisfactorily, has resulted in needless unemployment of the cardiac patient. The American Heart Association recognized these problems and was instrumental in establishing Work Evaluation Units sponsored by local heart associations, community agencies, industries, and hospitals.

The Maryland Cardiac Work Evaluation Unit supported by the Heart Association and the State of Maryland was organized in 1954. Patients with real or suspected heart disease are accepted for evaluation on referral from any private, industrial, or clinic physician. The unit, composed of a cardiologist, a vocational counselor, a medical-social worker, and a psychiatrist, evaluate each patient in an effort to correlate his current physical and emotional capacity with his previous or potential job. A history and physical examination, electrocardiogram, chest fluoroscopy and, where indicated, an electrocardiographic monitored test of exercise tolerance, are recorded.

On the basis of objective data, a functional and therapeutic classification for physical activity is formulated. The energy costs of various activities including self-care, housework, and industrial jobs have been estimated. In an evaluation of the patient by the vocational counselor, consideration is given to average requirements of the patient's usual occupation including peak loads as well as physical requirements of any potential employment.

The socioeconomic burden of the patient's illness and the home environment are examined. The patient's motivation and personality structure are considered. Finally, his physical and emotional capacity is weighed against his work requirements and an

employment prescription is forwarded to the referring physician for appropriate action. Since the Work Evaluation Unit of the Heart Association of Maryland was established, more than 3,300 patients have been evaluated. When seen, 70% were unemployed, although it was felt that almost 90% could return to gainful employment, two thirds to their old jobs. Those who were unable to return to their previous employment were assisted in making use of facilities of other agencies in the community such as Vocational Rehabilitation for appropriate guidance and for assistance in finding gainful employment. Continuous follow-up through mailed questionnaires has afforded a long-term evaluation of the unit's effort. In five-year follow-ups, more than 50% of the patients considered employable were working regularly. Especially significant has been the finding that only 15% were not working as a direct result of their heart disease.

Among patients seen at the work evaluation unit were patients with many different skills and work backgrounds, including: unskilled workers, managerial and executive personnel, farm workers, housewives, and professional people. The employment capacity of such individuals has been studied by the United States Department of Labor; 1,840 cardiac workers were compared with 3,055 workers without heart disease in the same types of jobs in more than 50 industries. There was only a small difference in job performance between the two groups. In fact, the cardiac worker was slightly more productive than the noncardiac workers.

Data from other work classification units are similar, providing evidence that a high proportion of patients with cardiovascular disease can and should work. When carefully evaluated and advised as to what they can or cannot do, they make good employees. The World Health Organization Expert Committee on Rehabilitation of Patients with Cardiovascular Diseases stressed that medical experience has shown that work appropriate to the cardiac status results in less harm than the psychological and socioeconomic consequences that inactivity itself provides for the family and the community as a whole.

With medical advances, an increasing number of heart patients will be salvaged with a larger group of such individuals seeking employment. The knowledge and experience gained through work evaluation units have made a significant contribution to the education of physicians, workers, and their employers, and has helped influence standard practices of insurance carriers. Most important, these units have expanded the cardiac's capacity for leading a useful life, maintaining self-esteem and making a significant contribution to society.

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DOUGLAS G. CARROLL, MD, EDITOR

Patterns of Medical Care in a Municipal Hospital

The medical care of the chronically ill patient is a major challenge to our present medical system. Institutional care is expensive, disorganized, and haphazard. There exists confusion as to goals, often accompanied by disinterest and callousness amongst the staff caring for such patients. This is a report on the results of a comprehensive approach to such patients, emphasizing the use of complete diagnostic methods and rehabilitation in its widest sense.

Fifty-one preplanned chronic admissions entered the Baltimore City Hospitals between July 4 and December 4, 1968. As a group, these patients were believed to need prolonged hospitalization but were not emergency admissions. Each patient had a Maryland State Chronic Hospital Application form filled out prior to admission. A decision was always made concerning whether the patient really needed hospitalization or whether other arrangements could be made which would meet his needs.

All admitted patients were given a complete diagnostic evaluation on the acute medical wards. This was done in the belief that a complete understanding of the patient's disease, response to therapy, social background, and evaluation in the Department of Physical Medicine and Rehabilitation, would lead to more appropriate long-term placement and better overall rehabilitation. I saw each patient shortly after admission, after which he was placed into one of three groups, based on the expectation of what could be done for him. **Group 1** consisted of patients with manifest neoplasms who were admitted for terminal care. There were 11 patients in this group. **Group 2** consisted of patients admitted for rehabilitation and recovery with the expectation that they could be discharged back to the facility or home in which they were, prior to admission. This group consisted of seven patients. One of these patients had an asymptomatic carcinoma of the prostate, but because he was not admitted primarily for this purpose, he is not included in Group 1.

Group 3 consisted of 33 patients with multiple diseases. They were admitted with the expectation that they would require permanent long-term care in some type of institution. Many of these patients were elderly, with complications of diabetes mellitus and atherosclerosis. Many had chronic brain syndrome associated with head injuries and strokes.

There were approximately equal numbers of men and women in each group and equal numbers of white and Negro patients. There was no significant difference as to the number of drugs the patients were on at admission (2 ± 1). About three consultations were called in for each patient in each group.

There were no significant differences in age. The patients with neoplasms tended to have had more previous hospital admissions and a shorter duration of illness than those in the other two groups. Those admitted for rehabilitation or recovery (Group 2) tended to have been sick for a longer period of time. The majority of the patients with neoplasms (Group 1) were transferred from another hospital to the Baltimore City Hospitals. The other two groups, however, received an equal number of patients from the home and as transfers from hospitals. The initial Activities of Daily Living scores were about similar in Groups 1 and 3 but significantly higher in Group 2. This finding was also true of the Mental Status Check List score (see Table 1).

The duration of time for initial workup and treatment in the acute medical service was similar in all three groups. Following the initial diagnostic

workup, completion of consultations, and establishment of a coordinated program for each patient, the patients were transferred to the chronic hospital (D Building).

	No.	Age Mean SD	No. Prev. Adm. M±SD	Duration Illness M±SD(mo.)	Source Transfer: Hosp/Home		ADL Score M±SD	MSCL Score M±SD	Time in days in A Bldg M±SD	Time in days in D Bldg M±SD	Disposition Died	N.H.	Home	Transfer	Still in D Bldg
Group 1	11	60±10	3±2.0	15±2	8	3	32±37	15±10	14±13	33±51	10	0	1	0	
Group 2	7	59±15	1±2.0	49±50	3	4	66±26	29±19	18±15	70±73	1	1	4	1	
Group 3	33	57±16	1±0.2	39±17	22	11	29±37	16±13	17±13	190±235	15	4	9	0	5

Table 1: Comparison of Certain Features of Three Groups of Preplanned Chronic Admissions

Patients in Group 1 had the shortest stay in the D Building, terminating in death in all except one patient who was discharged to his home. Patients in Group 2 spent about twice the time in the D Building as those in Group 1. There was only one death. One was discharged to a nursing home, four returned home, and one was transferred to a Veteran's Administration Hospital.

Group 3 was made up of patients for whom expert diagnostic facilities, availability of all therapeutic modalities, and prolonged hospital care resulted in little more than usually keeping the patient alive. These patients had very prolonged hospitalizations, five still being inmates of D Building after two years. Nearly one half died and four went to nursing homes. It is significant, however, that 27% were discharged to their homes despite all of the medical and social factors making such a disposition unlikely.

What Was Accomplished By Hospitalization?

Under ordinary circumstances, many of these patients might have been sent directly to nursing homes from other hospitals or from their own homes. The question arises then as to what facilities available in a hospital but not in a nursing home were of benefit.

Group 1: The admitting diagnosis of all these patients with neoplasms was confirmed in every case except one. In that case, the patient was found to have an adenocarcinoma of the kidney rather than a carcinoma of the prostate at post-mortem examination. One patient with proven carcinoma of the breast and atherosclerotic heart disease was found to have hypothyroidism and was treated for this. Two patients developed high calcium levels (one had carcinoma of the lung and the other had carcinoma of the pancreas). Both were expertly treated. This resulted in some prolongation of life but questionable overall benefit to the patient. One patient had brittle diabetes mellitus regulated adequately and because of this was able to be discharged to a nursing home. Post-mortem examination was performed in four of these patients and revealed unexpected pulmonary emboli in one patient and radiation pneumonia in another.

Thus, these patients were given expert and sophisticated medical care with possible prolongation of life. Diagnoses were confirmed and complications were treated.

Group 2: These patients received a number of benefits from hospitalization. Three patients experienced sufficient improvement in Activities of Daily Living to be able to take care of themselves at home. One patient had skin grafting; another had brittle diabetes mellitus that was adequately regulated, but he eventually died. One patient with cirrhosis of the liver suffered a gastrointestinal hemorrhage and was treated for it but eventually was transferred to a Veteran's Administration Hospital. Another patient suffered a fracture of the hip in the hospital.

These patients in Group 2 received a variety of specialized procedures such as plastic surgery, physical therapy, and medical treatment of a sophisticated sort, not generally available in a nursing home. The eventual return of four of these patients to their own homes seems a well justified use of hospitalization.

Group 3: This group was twice the size of the other two groups combined and consisted of patients with multiple diseases. These patients had very low ADL and MSCL scores. They remained in the hospital for prolonged periods and eventually had a high mortality rate. Since none of these patients at initial evaluation were expected to profit from hospitalization, it is important to identify the nine patients who actually were discharged back to their homes.

Case Patients

1. A 53-year-old man with a four-year history of myocardiopathy, congestive heart failure, and bilateral cerebral vascular accidents was received in transfer from another hospital. With removal of a gastric tube and mobilization, the patient was able to return home. He was then treated in the cardiac clinic for two years after discharge.

2. A 57-year-old man was admitted with a diagnosis of Parkinson's disease of a year's duration. Examination in the hospital showed that he had an

undiagnosed cerebral vascular accident. He was mobilized and his ADL score rose from 85 to 100. He was discharged home after only five months in the hospital.

3. A 60-year-old woman with a history of hypertension, diabetes, atherosclerotic heart disease, and congestive heart failure suffered a right hemipareses one year prior to admission. Over a two-month period it was possible to mobilize her. Her ADL score went from 45 to 100 and she was discharged and sent home.

4. A 58-year-old woman with a long history of diabetes mellitus and arteriosclerotic heart disease suffered a cerebral vascular accident a year before admission. Under appropriate physical therapy, her ADL score increased from 0 to 30 and she was discharged home but eventually had to be readmitted.

5. A 17-year-old girl with a severe head injury of 32 days' duration was transferred from a local hospital with a tracheostomy and a gastric tube. She had not been mobilized at the previous hospital, but shortly after admission to the Baltimore City Hospitals, the tracheostomy was closed. The tube was then removed and the patient rather rapidly threw off her lethargy and depression. She reached an ADL score of 100 and was discharged home.

6. A 40-year-old man suffered a severe brain injury with multiple fractures three months prior to transfer from another hospital to the Baltimore City Hospitals. His ADL admission score was 50. A Foley catheter was removed. He was then mobilized. His ADL score went up to 90, and it was possible to discharge him after five months.

7. A 62-year-old woman was admitted to the Baltimore City Hospitals three months after having suffered a subdural hematoma which was appropriately treated at another hospital. Under physical therapy she developed full independence and was discharged to her home nine months after admission.

8. A 41-year-old man suffered a bullet wound of the left carotid with a right hemiplegia, 35 days prior to transfer to the Baltimore City Hospitals. His ADL admission score was 80 and he was under physical therapy. Soon, however, he attained a score of 100. He was unable to speak but could follow directions. He remained in the hospital for seven months.

9. A 76-year-old woman suffered a right hemiplegia two months prior to admission. She also had atherosclerotic heart disease. On admission her ADL score was 65. However, under physical therapy she rapidly reached a score of 100, which was sufficient to allow self-care in her home and discharge.

The majority of patients in this group were expected to do poorly. However, with intensive mobilization of available facilities in the hospital, it was possible to discharge nine of them to their own homes.

Evaluation

There is little need to emphasize the increasing number of elderly patients with multiple diseases coming to hospitals for medical care today. One reason for the increased number is that children are no longer so willing to care for their sick parents at home. Government programs are tending to pay for hospitalization for some of these patients, thus further removing responsibility from the family. Hospitals are no longer feared as much as formerly, and there is an expectation that modern methods of treatment are effective. Perhaps the greatest cause of the increased number of elderly sick, however, is that patients who formerly would have died are living longer and developing multiple diseases. Powerful drugs and new techniques allow survival of patients who formerly would have died. The result is that many of these elderly patients, in addition to multiple organic diseases, are also depressed, passive, and overwhelmed by social and financial problems.

Our approach to this problem at the Baltimore City Hospitals has been:

1. Each patient must have a comprehensive (medical, mental, psychological, social, and financial) evaluation.

2. These evaluations must be coordinated into a specific plan for each patient.

3. Elaborate diagnostic procedures are required and indicated as necessary for comprehensive planning.

4. The justification for this approach is not to be based on the discovery of a large number of potentially treatable diseases, but rather based on the identification of an occasional unexpected finding which may be of help to these patients.

5. The goal of this approach is to cure, if that is possible. More often than not, the goal will be to modify the disease, emotional state, social, or financial problems. Often, the goal is to teach the patient or the family to live more happily with its problems.

6. Individual patient benefit is the underlying goal. Family, hospital, house staff, and community benefit are also important ingredients, however, in outlining an individual program for each patient.

Summary

Fifty-one preplanned chronic admissions were admitted to Baltimore City Hospitals in the fall of 1968. These were patients selected from the community by hospitals, families, and local physicians with the thought that they needed prolonged care in an institution. Many of these patients under ordinary circumstances might have been admitted directly to a nursing home.

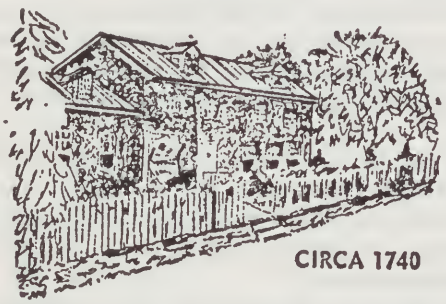
Under the program at the Baltimore City Hos-

pitals, each one of these patients was admitted, and carefully evaluated from the diagnostic, therapeutic, rehabilitation, social, and financial viewpoint. An individual specific program was outlined with a goal of making the patient as independent as possible. The patients were divided into three groups. Group 1 consisted of patients with terminal cancer. The major problem was to administer terminal care with as little anxiety and as much support of the patient as possible.

The remaining patients were divided into two groups. Group 2 patients (seven) were believed to have potential for improvement under the program outlined. Group 3 patients (33) were thought to require prolonged institutional care with little potential for improvement. The prediction of potential improvement in Group 2 was fulfilled. In Group 3, nine patients improved unexpectedly. This proved that rehabilitation potential was not always recognized at the initial evaluation.

Programs which are free to take advantage of the patient's improvement under treatment are, therefore, necessary to make certain that optimal benefit accrues to all patients. It is only by recognizing this fact that a rehabilitation program such as I have described can ever really succeed.

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ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Clinics Open, Aides Meet and Medical Workers Join Staff

In response to community requests for prenatal, well-baby, and family planning services, the Baltimore City Health Department has opened a new clinic center at 4200 Edmondson Avenue. The center is unique in that it is housed in a medical building where several private physicians are also available to assist patients with special problems not covered in the clinics. It also incorporates many of the community's suggestions about the types of clinics that should be available.

Another innovation is the assignment of a clinic manager and a health aide on a full-time basis. Thus, someone is always available to help patients when clinics are not in session. A full team of physicians, public health nurses, and health aides from the Western Health District will be present for clinic sessions only.

The present schedule of clinics is: Monday, prenatal clinic; Tuesday, well-baby clinic; Wednesday, family planning clinic; and Thursday, well-baby clinic. All clinics will be open for service on their individual days at 8:30 AM. They will remain open until all patients are served. This schedule will be modified if the community shows a need for more clinic time.

Tuberculosis Aides Receive National Recognition

A small symposium on the use of paramedical personnel in tuberculosis control was recently presented by the Tuberculosis Division of the Baltimore City Health Department in Atlanta, Georgia. The symposium was part of the meeting of tuberculosis controllers called by the National Center for Disease Control on October 5 and 6, 1970.

Allan S. Moodie, MD, presented the main paper while Mrs. Selma Wilson and Mrs. Frances Taylor, health aides, presented supporting papers describing their functions in working in the field and with industrial tuberculin testing, respectively.

At this meeting too, Phyllis Q. Edwards, MD, Chief of the Tuberculosis Branch of the Center for Disease Control, cited the Baltimore City Health Department for its practical and economical control program which is now meeting with considerable success.

Medical Social Workers Appointed

Three medical social workers have been appointed to the staff of the Baltimore Maternity Center, 211 W. Lombard Street. They are: Mrs. Jimmie Poindexter, formerly of Prairie View, Texas; Miss Theresa Chan, Baltimore; and Mrs. Barbara Shulman, also of Baltimore.

Under the direction of Miss Carolyn White, chief of the social services unit, the new staff members will assist maternity patients who have no family physician with home and maternity problems related to their pregnancies.

Mrs. Poindexter, a graduate of Prairie View College, holds the master of social work degree from Howard University and has been employed in social work in both Texas and Baltimore. For the past four years she has been a social worker in the Baltimore City Department of Education. Mrs. Poindexter will serve as Medical-Social Work Supervisor.

Miss Chan, previously a social-work assistant at the University of Maryland Hospital, attended Western High School and is a 1970 graduate of the University of Maryland.

Mrs. Shulman attended Forest Park High School and received her bachelor's degree from the University of Maryland also. For the past year, she has been teaching in Clarksville, Maryland.


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*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

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The Doctor

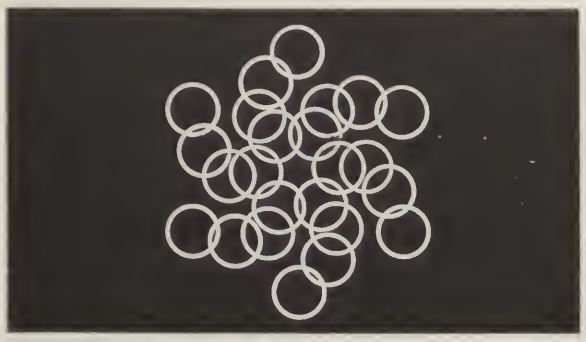
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From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Treatment of Acute Intoxication: (Part) I

NELSON J. BRADLEY, MD
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The acute alcoholic is frequently either not accepted by general hospitals or, if accepted, is automatically admitted. Obviously, all general hospitals should be accepting acute alcoholics, but not all alcoholics should be automatically admitted. A differential diagnosis is called for in each case. The decision of whether or not to admit an alcoholic should be based on the old standby of a good history and a physical.

The alcoholic patient is classically a poor reporter and, because of preoccupation with his presenting problem and the loss of control of his drinking and its consequences, he is irritated by the need for a detailed inquiry into his general physical condition. The person presenting the alcoholic is just as frequently a poor reporter. In spite of the fact that this person may even be married to the alcoholic, the spouse frequently has not been in close contact. Often the spouse, too, has not been aware of or concerned about other possible medical problems. When the primary concern is to unload the alcoholic, reporting will be even more inadequate. An attempt at a careful history is therefore fundamental in the management of the acute phase, and a carefully recorded history is a very good precaution.

The degree of intoxication seems to be the main criteria as to whether or not an alcoholic should be admitted. Frequently, the main objection to admitting an alcoholic to a hospital is that he is noisy, recalcitrant, hostile, aggressive, abusive, and overactive. If he is capable of that kind of behavior, ie, if he is conscious enough to argue about his legal rights and is in enough control of the motor portion of his central nervous system to physically resist, it is usually fairly safe to refuse admission. In fact, to refuse him admission very often results in his becoming much more pliable and cooperative. The physician should concentrate concern on reassuring the distracted spouse or friend and return the responsibility to them.

Sometimes the accompanying person drops the alcoholic at the hospital and runs. A proper procedure then is to get the correct address from the alcoholic, call a taxi and return him to this address. If it is the local police who leave him, make certain that the recalcitrant alcoholic is returned to their care. The responsible emergency ward will obviously not allow the intoxicated person to leave in his own automobile. The hospital very frequently is not equipped to stop the alcoholic, but it can be responsible enough to call the police and inform them that an intoxicated person has just left the premises and intends to drive. It is effective to send an alcoholic home with a sedative and to give him another dose to take with him. This obviously can only be done with a responsible person present, such as the spouse or friend.

The alcoholic person who is not overactive and abusive, but is in some stage of somnambulance or coma, presents a different problem. Here we really have a problem of differential diagnosis. This is why I offered the precautionary note on the ac-

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curacy of alcoholic histories. The procedures are no different than the procedures for any coma. We have a patient who: 1) has all the complications of acute ethynol poisoning; 2) is very susceptible to trauma of every conceivable kind; 3) is much more susceptible to acute infection involving any system of the body; and 4) is quite likely to have such medical emergencies as anuria, pancreatitis, or ruptured peptic ulcer—all of which are difficult enough in themselves to diagnosis in the early stages. There is a much higher incidence of the chronic dehabilitating diseases. Diabetes and malnutrition are fairly common. Most frequently, the alcoholic has chronically neglected all aspects of his physical health.

The diagnosis of alcohol coma should be arrived at through the routine set-up for any patient who comes in with some degree of coma. Alcohol blood levels, barbiturate levels, sodium potassium levels, and magnesium levels are a part of any good routine.

The diagnosis of delirium tremens is standard. The practice of sedating a person who is obviously in delirium tremens and then phoning to find a hospital which has an admitting policy that accepts DT's is inexcusable. This is a medical emergency which is somewhere between 15% and 30% fatal unless it is properly managed. The promiscuous use of sedation to control the patient just for the ambulance ride or, more frequently, for the family car ride to the more enlightened hospital, vastly complicates the management of the patient.

The "saturated alcoholic" is an obviously intoxicated person who is not belligerent or aggressive and has not lost any consciousness. He looks very ill. Fearful and alert, extremely tense and anxious, he is usually most cooperative. When the emergency room calls a physician and describes a condition as being neither belligerently out of hand, nor in coma, there is a tendency for the physician to order sedation and have him sent home. Frequently the emergency room will call the physician again within the hour. For some reason, even unknown to themselves, they have not sent this alcoholic home. They have been impressed by the fact that this person looks very "sick". The tense desperateness of this type of alcoholic is obvious as he tries to minimize every kind of sensory stimulus, both external and internal. In such a condition he usually gives a very accurate history, but speaks only in monosyllables.

Delirium tremens may not be imminent, but the person should be treated the same as if he had DT's. He very often will respond remarkably to this routine, and then the question arises if all these heroics were necessary. If you neglect giving him the full treatment, you very often will have a difficult case of delirium tremens on your hands. These patients frequently have a leukopenia and a very slightly elevated temperature and a hyperreflexia as immediate presenting symptoms.

Control is Necessary

When the belligerent, recalcitrant alcoholic is admitted, control is necessary because such a patient is impossible to manage on the ward. Rather generous doses of intramuscular sedation is a fairly safe way to accomplish control. Actually, sedation is indicated for almost every alcoholic admission because of the degree of anxiety.

As long as the patient is anxious, it will be difficult to restore his various functions to their natural state.

Extreme anxiety, which is crippling to even the nonintoxicated alcoholic, results in an abnormal physiological situation. There is no system in the body that is not involved in this phenomenon. The state of uncontrolled anxiety is really very similar to Dr. Selyes' second stage of the stress reaction, and this eventually leads to the exhaustion of the various systems involved.

The best sedative and tranquilizer for the acutely intoxicated and also the very anxious alcoholic, however, is a well qualified and experienced staff. The situation is then met with a sense of sureness, calmness, firmness, and a neutral attitude. When you have this, the simple tranquilizer routines, and sometimes even the vitamin routines used by certain alcoholic treatment centers, have produced results not duplicated by inexperienced hospitals. Glowing results are very often attributed to various drug effects by hospitals which have a policy of accepting alcoholics as sick people. These results may well be attributed to a trained, knowledgeable, and empathetic staff.

There is no room for coddling an alcoholic admission. He reacts just as poorly to this as he does to a hostile, angry staff environment. He particularly reacts to inefficiency and deceit. The wife, for instance, may want the patient told that he is being admitted to a medical floor, when actually it will be a psychiatric floor. It is disastrous for the staff to go along with this type of deceit. Trying to cajole or threaten an alcoholic will hinder more than help. Usually when you just tell an alcoholic the way things are, he very often complies. Resistance immediately appears at the slightest indication of hostility or the slightest indication of fear or weakness. He is unable to respond any differently to these inconsistencies. Very often the alcoholic has enough alcohol in his system that an atmosphere of reassurance and confidence is enough to put him to sleep.

The goal is a state of natural sleep. This article will not dwell on the complications of over-sedating. They are exactly the same as that of a prolonged anesthetic. Under-sedating brings on all the complications any prolonged stress situation creates in our physiology.

Actually, the time of day of admission is im-

portant in the combination of sedation and tranquilization. The intoxicated alcoholic should be restored as quickly as possible to the natural rhythm of an ordinary day. During the first day in the hospital, when the effort is to reassure the patient that he is being withdrawn without any unnecessary suffering, he should have enough tranquilizer so that he can lie down and sleep, yet be alert enough to eat his three meals.

A careful routine would give a patient an intermuscular prochlorperazine (*Compazine*) 1 or 2 cc depending on his size, two hours prior to lunch and possibly prior to the first supper. This settles the butterflies well enough to allow him to eat and retain his first lunch and his first supper. The first night in the hospital the patient should sleep soundly. This means using one of the barbiturates (preferably *Amytal* or *Tuinal*) in large enough doses. These should be repeated, if necessary, and given either orally or intermuscularly as indicated.

The choice of tranquilizers is academic, and the reader can refer to the various literature on the subject. Most tranquilizers have an adequate variety of doses plus an intermuscular dose. Some physicians prefer to stay with those tranquilizers that do have the intermuscular as well as the oral. Mixing tranquilizers is not particularly contraindicated. The long-acting spansules have some considerable merit in the later days of hospitalization.

Problems with Tranquilizers

One of the objections to the use of tranquilizers is the complication of lowering the convulsive threshold. Convulsions have always been a complication of alcohol withdrawal. The fact that alcoholics have quite likely used tranquilizers prior to admission and that we are using them in the management of the acute intoxication in the hospital, has tremendously increased the problem of alcohol convulsions. This is a grand mal, extremely unpredictable convulsion, which makes these people very injury prone. They never seem to have the warning of the epileptic grand mal. It certainly appears that the claims of less convulsions with chlordiaze poxide hydrochloride (*Librium* and *Valium*) are valid. Convulsions seem most prevalent with the use of promazine (*Sparine*) although this is an extremely effective tranquilizer for withdrawing the alcoholic.

The phenothiazines are not an effective anticonvulsant. They are more prone to create another complication—hypotension. Hypotension is relatively rare with oral medication and can be further prevented by bed rest after an IM dose. The contraindication of the phenothiazines in a person who obviously has a damaged liver has not proved to be valid. As a matter of fact, the decompensating liver seems to handle phenothiazines better than either *Librium* or *Valium*. The alcoholic with the decompensating liver occasionally cannot handle even the smallest doses of *Librium* and becomes completely ataxic and drowsy. Reducing the dose does not seem to be the answer. The drug has to be completely withdrawn.

The problem of contraindication because of the addictive proneness of the alcoholic to tranquilizers is an interesting but overrated phenomenon. It does, however, call for some consideration. There are vast differences in the so-called addicting potential of the various tranquilizers. The only tranquilizer that has become an abuse problem is meprobamate. There seems to be enough indication to preclude their use in the management of alcoholism in either the acute or chronic state. Certainly the phenothiazines are the safest on this score. What appears to be the habituating factor in the tranquilizers is in direct correlation with their ability to reduce anxiety. The meprobamates, which seem to be the most effective in the immediate reduction of anxiety, are also the most habituating. Their closest competition in anxiety reduction—*Librium* and *Valium*—also have some problems with habituation. The less dramatic anxiety reducers, such as the various phenothiazines, rarely become an habituation problem with the alcoholic patient. The old rule of never giving the patient the drug he asks for certainly applies in all these cases.

The alcoholic, however, should not be threatened with withdrawal. The acutely intoxicated alcoholic, which an experienced staff is managing in a general hospital, can be withdrawn from all tranquilizers in most cases within four to five days. The best routine is to use the same tranquilizer with the same frequency but in decreasing doses so that you can decrease the dosages to 25, 10, and 5; or 10, 5, and 2. The patient will be down to 0 within these four to five days. This routine does not seem to threaten the alcoholic's dependent needs nor does it arouse fears of rejection. If it is not effective, it implies that you do not have the kind of personnel working with the alcoholic who are capable of reducing anxiety by their management and relationship to the patient. Perhaps you have an alcoholic who has a problem with other addictions than just ethynol. He may have anxieties beyond the anxieties that are usually part of the alcohol addiction and his withdrawal symptoms.

The saturated alcoholic is not going to respond to a simple q.i.d. tranquilizer but will most likely need the addition of intermuscular medication to give him rest. Sound sleep is essential. The early breakfast, the perfunctory efficiency of the lab technicians, physicians' rounds, and other hospital services and routines are not nearly as valuable as a state of natural sleep in the first 24 hours.

The most controversial sedatives are the barbiturates. The primary reasons for choosing barbi-

turates is that they are the most effective sedative. They are also the most flexible in length of action and can be given orally, IM, or IV. Since sodium amytal is not too effective an anticonvulsant, it would seem best to use phenobarbital or intermuscular sodium luminal. There are several programs which report successful use of these drugs. These drugs, however, are difficult to control because of long and sometimes delayed action. They also have a depressant effect on the alcoholic. These are strong contraindications for their use. Secobarbital (*Seconal*) and pentobarbital (*Nembutal*) are precluded because alcoholics are extremely susceptible to habituation and eventually addiction to these drugs.

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Library Co-Sponsors Meeting

The Washington, D.C. Area Medical Library Group, organized in 1952, met in Baltimore this year for its 1970 session. It was sponsored jointly by the Health Sciences Library, the University of Maryland, and the Medical and Chirurgical Faculty of Maryland Library. Instrumental in originally organizing this regional association were Miss Estelle Brodman, Mrs. Ida Marian Robinson, and Mr. Scott Adams. Since 1952, the medical library community has grown considerably and this year has added the North Carolina medical librarians to its group.

Mrs. Robinson, Librarian Emeritus, Health Sciences Library, University of Maryland, made the introductory remarks. Miss Myrl Ebert, Librarian, Health Sciences Library, North Carolina Memorial Hospital, University of North Carolina, Chapel Hill, North Carolina, spoke on behalf of the North Carolina delegation. An invitation was extended for the next meeting (October 1971) by Mrs. Erika Love, Librarian, Wake Forest University Library, Bowman Gray School of Medicine, to Winston-Salem, North Carolina.

Three outstanding speakers contributed to the varied program of the conference. Mrs. Mary M. Baxter, former Chief Programmer, SUNY (State University, New York) explained the Biomedical Communication Network in Upstate Medical Center, Syracuse, New York, and presented an enlightening account of the activities and status of the network.

The Multimedia, Self-Instruction Project of the School of Nursing, University of Maryland, was explained by Mrs. Ada M. Lindsey, Assistant Professor, University of Maryland School of Nursing. The original grant for this project was $700,000, with $160,000 a year provided for operation. The project is now 1½ years old. Units of actual nursing equipment are prepared for circulation to students as are supplementary teaching aids to be used in conjunction with tapes, slides, and movies.

Norman S. Stearns, MD, Executive Director, Postgraduate Medical Institute, West Newton, Massachusetts, gave an illustrated paper on his idea of the integrated health sciences core library for physicians, nurses, and allied health practitioners in community hospitals. Dr. Stearns views the library as a health sciences learning center and sees the role of the librarian in this setting mainly as an educator. Following his speech, a number of searching questions were asked and all librarians present, especially from community hospitals, must have left with a somewhat new outlook on their own library.

Anyone wishing copies of the list of publications on this subject, by Dr. Stearns and others, may secure copies by writing to the Medical and Chirurgical Faculty Library.

* * *

On January 21, 1971, at 2 PM, the Baltimore Hospital Librarians Association at Union Memorial Hospital will meet to discuss both the philosophical view of nursing libraries and the use of audiovisual media in small medical libraries.

* * *

A pilot issue of the *Bibliography of Medical Bibliographies* was distributed recently by the Health

Sciences Bibliographic Clearinghouse which was established as a part of the Reference Services Division, Reference Section, National Library of Medicine in 1969.

This is a pilot project which provides an index to both published and unpublished bibliographies in biomedicine. In the pilot issue, bibliographies from 1967 to date have been included, omitting regularly recurring bibliographies and review articles already indexed in the *Bibliography of Medical Reviews*. However, lengthy bibliographies from biomedical monographs are included if complete citations are given.

The complete citation is given first, listed alphanumerically, with a KWIC index by keyword following. However, an author index, which could be helpful, is lacking.

If you wish to receive a copy, write: Edith D. Blair, Project Officer, Health Sciences Bibliographic Clearinghouse, Reference Section, Reference Services Division, National Library of Medicine, Rockville Pike, Bethesda, Maryland 20014.

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Adams, E.B.; Laurence, D.R.; Smith, J.W.G.
Tetanus. Oxford, Blackwell, 1969.

Advisory Conference on Key Issues in Reducing Infant Mortality, Washington, 1969.
Key issues in infant mortality. Report of a conference. Frank Falkner, scientific editor. Bethesda, Md., National Institute of Child Health and Human Development, 1969.

Allen, Clifford
A textbook of psychosexual disorders. 2d ed., London, Oxford University Press, 1969.

American Academy of Neurology
Membership directory, 1970. Minneapolis, 1970.

American Association of Hospital Consultants
Functional planning of general hospitals. New York, McGraw-Hill, 1969.

American drug index, 1970. By Charles O. Wilson and Tony Everett Jones. Philadelphia, Lippincott, 1970.

American Heart Association
Standards for a cardiac catheterization laboratory; a guide for cardiologists and for institutions sponsoring cardiac catheterization laboratories. New York, 1970.

American Medical Association
Listing of group practices in the United States. 2d ed. Chicago, 1967.

American Medical Education. Council on Medical Education.
Continuing education courses for physicians for the period from Sept. 1, 1970 through Aug. 31, 1971. Chicago, 1970 (JAMA, v. 213, no. 5, Aug. 3, 1970).

American Psychiatric Association. Committee on Nomenclature and Statistics.
Diagnostic and statistical manual of mental disorders. 2d ed. Washington, 1968.

Annual Clinical Conference on Cancer, M.D. Anderson Hospital and Tumor Institute, Houston, 13th, 1968.
Breast cancer; early and late. Chicago, Year Book Medical Pub., 1970.

Apley, Alan Graham
Recent advances in orthopaedics. Baltimore, Williams & Wilkins, 1969.

Automated multiphasic health testing bibliography, v. 1, no. 1, 1970. Baltimore, U.S. Dept. of Health, Education and Welfare, Health Services Research Branch. (U.S. Public Health Service. Publication no. 2076).

Black, Douglas Andrew Kilgour
Renal disease. 2d ed. Philadelphia, Davis, 1967.

Bloodstein, Oliver
A handbook on stuttering. Chicago, National Easter Seal Society for Crippled Children and Adults, 1969.

Bowers, Warner Fremont
ECFMG examination review, part 1. 2d ed. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book).

Bowers, Warner Fremont
Surgery; 2,000 multiple choice questions and referenced answers on general surgery and surgical specialties. 4th ed. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book, v. 5).

Bowers, Warner Fremont
Surgery; specialty board review; 1,250 advanced multiple choice questions and referenced answers derived from current surgical journals. 3d ed. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Medical examination review book).

Boyd, William
A textbook of pathology. 8th ed. Philadelphia, Lea & Febiger, 1970.

Brown, Robert C.
Anesthesiology; 2,000 multiple choice questions and answers referenced to journals and textbooks in anesthesiology. 3d ed. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Medical examination review book, v. 12).

Buck, Alfred A.
Health and disease in Chad. Baltimore, Johns Hopkins Press, 1970.

Current drug handbook, 1970-72. By Mary W. Folconer, H. Robert Patterson, and Edward A. Gustafson. Philadelphia, Saunders, 1970.

Daniel, William A.
The adolescent patient. St. Louis, Mosby, 1970.

De Jong, Rudolph H.
Physiology and pharmacology of local anesthesia. Springfield, Ill., Thomas, 1970.

Derbyshire, Robert Cushing
Medical licensure and discipline in the United States. Baltimore, Johns Hopkins Press, 1969.

DiDido, Liberato J. A.
Synopsis of anatomy. St. Louis, Mosby, 1970.

Directory of medical specialists certified by American boards. v. 14, 1970/71. Chicago (Marquis—Who's Who).

European Meeting on Electroencephalography. 15th, Bologna, 1967.
The abnormalities of sleep in man; proceedings. Gestaut, et al ed. Bologna, Gaggi, 1968.

Farb, Stanley N.
Otolaryngology; 1200 multiple choice questions and answers referenced to textbooks and journals. 2d ed. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Medical examination review book, v. 16).

Fraser, Robert G.; Pare, J. A. Peter
Diagnosis of diseases of the chest; an integrated study based on the abnormal roentgenogram. Philadelphia, Saunders, 1970.

Fulcher, Jane M.
Medical librarian examination review book; 1,500 multiple choice questions and referenced answers. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Medical examination review book).

Geeraets, Walter J.
Ocular syndromes. 2d ed. Philadelphia, Lea & Febiger, 1969.

Gellis, Sidney Saul
Atlas of mental retardation syndromes; visual diagnosis of facies and physical findings. Washington, Division of Mental Retardation, Rehabilitation Services Administration, 1968.

Gibbon, John Heysham
Surgery of the chest. 2d ed. Philadelphia, Saunders, 1969.

Gibbs, D. D.
Exfoliative cytology of the stomach. New York, Appleton-Century-Crofts; London, Butterworth, 1968.

Gilbert, Leopold
Medical state board examination review book; questions, answers, diagrams from past examination. 4th ed. Flushing, N.Y., Review Book Pub., 1969 (Medical examination review book).

Goodman, Louis Sanford and Gilman, A.
The pharmacological basis of therapeutics. A textbook of pharmacology, toxicology, and therapeutics for physicians and medical students. 4th ed. New York, Macmillan, 1970.

Gottlieb, Marvin I.
Anatomy review; 1,500 multiple choice questions and answers, completely referenced. 4th ed. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Basic science review series).

Gottlieb, Marvin I.
Pediatrics; 2,000 multiple choice questions and answers referenced to textbooks. 4th ed. Flushing, N.Y., Medical Examination Publ. Co., 1970 (Medical examination review book, v. 11).

Griffith, Valerie Eaton
A stroke in the family; a manual of home therapy. New York, Delacorte Press, 1970.

Hall, Calvin Springer
Theories of personality. 2d ed. New York, Wiley, 1970.

Harris, Maurice Coleman
All about allergy. Englewood Cliffs, N.J., Prentice-Hall, 1969.

Healey, John E. and Seybold, W. D.
A synopsis of clinical anatomy. Philadelphia, Saunders, 1969.

Hershey, Ronald A.
Physical therapy examination review book; 2000 multiple choice type questions and referenced answers. Flushing, N.Y., Medical Examination Pub. Co., 1966-70 (State board examination review book).

Hirshfeld, Daniel S.
The lost reform; the campaign for compulsory health insurance in the U.S. from 1932-1943. Cambridge, Harvard University Press, 1970.

Hospital liability law; lectures and trial demonstration. Edited by Virginia Davis Nordin et al. Ann Arbor, Mich., Institute of Continuing Legal Education, 1968.

Hubbard, J. I.
Electrophysiological analysis of synaptic transmission. By J.I. Hubbard, R. Llinás, and D.M.J. Quastel. Baltimore, Williams & Wilkins, 1969 (Monographs of the Physiological Society, no.19).

Huestis, Douglas W.
Practical blood transfusion. By Douglas W. Huestis, Joseph R. Bove and Shirley Busch. Boston, Little, Brown, 1969 (Series in laboratory medicine, 3).

Idiopathic respiratory distress syndrome; proceedings of interdisciplinary conferences. Respiratory distress syndrome: scope of the problem, Nov. 15, 1967, Bethesda; Idiopathic respiratory distress syndrome: prematurity as a contributing factor, March 13, 1968, Bethesda; Idiopathic respiratory distress syndrome: therapeutic approaches, April 30, 1968, Atlantic City. Scientific editor: Joseph Dancis. Bethesda, U.S. National Institute of Child Health and Human Behavior, Perinatal Biology and Infant Mortality Branch, 1969.

Illingsworth, Ronald Stanley
The development of the infant and young child, normal and abnormal. 4th ed. Baltimore, Williams & Wilkins, 1970.

Ingram, John Thronton
Clinical dermatology; an individual approach. London, Churchill, 1969.

International Congress of Medical Librarianship. 3d, Amsterdam, 1969.
Proceedings. Edited by K. Ellison Davis and W.D. Sweeney. Amsterdam, Excerpta Medica, 1970 (Excerpta medica. International congress series, no. 208).

International Planned Parenthood Federation.
Population. Rev. London, 1970.

Kosa, John
Poverty and health; a sociological analysis. Edited by John Kosa, Aaron Antonovsky, and Irving Kenneth Zola. Cambridge, Harvard University Press, 1969.

Kracum, Vincent D.
Inhalation therapy examination review book, v.1, 1200 multiple choice questions and referenced answers. Flushing, N.Y., Medical Examination Pub. Co., 1970 (State board examination review book).

Laffin, John
Surgeons in the field. London, Dent, 1970.

Leis, Henry Patrick
Diagnosis and treatment of breast lesions. Flushing, N.Y., Medical Examination Pub. Co., 1970.

Lieberman, Alvin
Air-pollution-monitoring instrumentation, a survey. By Alvin Lieberman and Peter Schipma. Washington, U.S. National Aeronautics and Space Administration, Office of Technology Utilization, 1969.

Lynch, William B.
Should you incorporate your practice? Los Angeles, 1970.

Lynn, Kenneth C.
Directory of medical libraries for dentists in the state of Maryland. Prepared for the annual meeting of the Maryland State Dental Association, Sept. 30, 1969. Bethesda, U.S. National Institute of Dental Research, 1969.

Maimonides, Moses
Treatise on hemorrhoids; medical answers (Responsa). Translated and edited by Fred Rosner and Suessman Munter. Philadelphia, Lippincott, 1969.

Medical and Chirurgical Faculty of the State of Maryland.
Compendium of decisions dealing with ethics, propriety and legality governing the practice of medicine in Maryland. Baltimore, 1970.

Medical malpractice: patient vs. physician. Cambridge, Mass., American Trial Lawyers Association, 1970 Trial, v. 6, no. 2, Feb/Mar. 1970).

Monroe, Russell R.
Episodic behavioral disorders; a psychodynamic and neurophysiologic analysis. Cambridge, Harvard University Press, 1970.

Mumford, Emily
Interns; from students to physicians. Cambridge, Harvard University Press, 1970.

Mussen, Paul Henry
Readings in child development and personality. By Paul Henry Mussen, John Janeway Conger and Jerome Kagen. 2d ed. New York, Harper & Row, 1970.

Neurochemistry in the Soviet Union; report of the neurochemistry delegation to the USSR, Nov. 11-25, 1969, under the U.S.-Soviet exchange program in the health and medical sciences. Editor: Donald B. Tower. Washington, U.S. National Institute of Neurological Diseases and Stroke, 1970.

Novak, Edmund Rogers
Textbook of gynecology. By Edmund R. Novak, Georgeanna Seegar Jones and Howard W. Jones. 8th ed. Baltimore, Williams & Wilkins, 1970.

Pinkus, Hermann
A guide to dermatohistopathology. By Hermann Pinkus and Amir H. Mehregan. New York, Appleton-Century-Crofts, 1969.

Progress in surgery, v. 8, 1970. Editors: M. Allgower et al. Basel, Karger.

Probst, Raymond E.
Obstetrics and gynecology; specialty board review; 1500 multiple choice questions and referenced answers. 3d ed. Ed. by Raymond E. Probst and Thomas M. Mier. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book).

Reger, Roger
Preschool programming of children with disabilities. Springfield, Ill., Thomas, 1970.

Reuben, David R.
Everything you wanted to know about sex but were afraid to ask. New York, McKay, 1969.

Rorvik, David M.
Your baby's sex: now you can choose. By David M. Rorvik and Landrum B. Shettles. New York, Dodd, Mead, 1970.

Rushmer, Robert Frazer
Cardiovascular dynamics. 3d ed. Philadelphia, Saunders, 1970.

Sawin, Clark T.
The hormones; endocrine physiology. Boston, Little, Brown, 1969.

Schick, Frank L.
Directory of health science libraries in the United States, 1969. Edited by Frank L. Shick and Susan Crawford. Chicago, Medical Library Association, 1970.

Schneeberg, Norman G.
Essentials of clinical endocrinology. St. Louis, Mosby, 1970.

Sex Information and Education Council of the U.S.
Sexuality and man. New York, Scribner, 1970.

Shapiro, Jerome H.
Radiology; 1475 multiple choice questions and answers referenced to textbooks and journals. Edited by Jerome H. Shapiro and Florencio A. Hipona. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book, v. 17).

Shuster, Sam
Systemic effects of skin disease. By Sam Shuster and Janet Marks. New York, Appleton-Century-Crofts, 1970.

Siegel, Rudolph E.
Galen's system of physiology and medicine; an analysis of his doctrines and observations on bloodflow, respiration, humors and internal diseases. Basel, Karger, 1968.

Slosberg, Paul S.
Psychiatry and neurology; 1400 multiple choice questions and referenced answers. 4th ed. Rev. and ed. by Paul S. Slosberg and Paul Salkin. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book, v. 8).

Smith, Donald R.
General urology. 6th ed. Los Altos, Calif., Lange Medical Pub., 1969.

Surgery annual. v. 1, 1969. Editor: Philip Cooper, New York, Appleton-Century-Crofts.

Sykes, Malcolm Keith
Respiratory failure. By M.K. Sykes, M.W. McNicol and E.J.M. Campbell. Oxford, Blackwell, 1969.

Thomas, Charles I.
Ophthalmology; 2935 multiple choice questions and answers referenced to textbooks and journals. 2d ed. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book, v. 15).

Thompson, Malcolm Keith
Geriatrics and the general practitioner team. London, Bailliere, Tindall & Cassell, 1969.

Tracht, Myron E.
Pathology; 1500 multiple choice questions and referenced answers. 2d ed. Flushing, N.Y., Medical Examination Pub. Co., 1969 (Medical examination review book).

Turk, David Charles
A short textbook of medical microbiology. By D. C. Turk and I. A. Porter. 2d ed. London, English Universities Press, 1969.

U.S. National Cancer Institute, Research Information Branch.
Research on malignant diseases of the brain. Washington, U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Institutes of Health, 1970.

U.S. National Clearinghouse for Smoking and Health.
Directory of on-going research in smoking and health, 1970. Compiled by Herner and Co., Arlington, Va., U.S. Dept. of Health, Education and Welfare (U.S. Public Health Service. Publication no. 1665).

U.S. National Library of Medicine
The principles of MEDLARS. Bethesda, Md., 1970.

Varano, Nicholas R.
Urology; 1350 multiple choice questions and referenced answers. 2d ed. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Medical examination review book, v. 14).

Walden, Richard T.
Public health and preventive medicine; 1200 multiple choice questions and answers referenced to textbooks. 4th ed. Rev. and ed. by Richard T. Walden and Raymond O. West. Flushing, N.Y., Medical Examination Pub. Co., 1970 (Medical examination review book, v. 6).

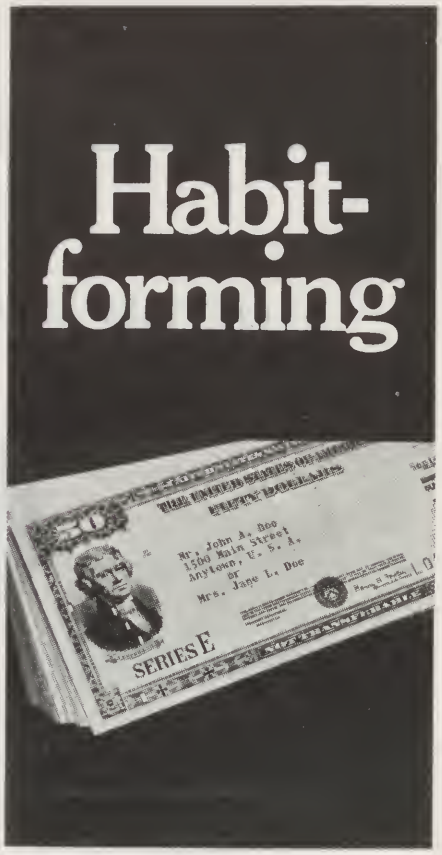
Weiner, Irving B.
Psychological disturbance in adolescence. New York, Wiley, 1970.

Zaidi, S. H.
Experimental pneumoconiosis. Baltimore, Johns Hopkins Press, 1969.

Zwell, Mary Etta
Training for family practice, a selected bibliography by Mary Etta Zwell and Lucy Zabarenko. Pittsburgh, University of Pittsburgh, Dept. of Psychiatry, 1970.

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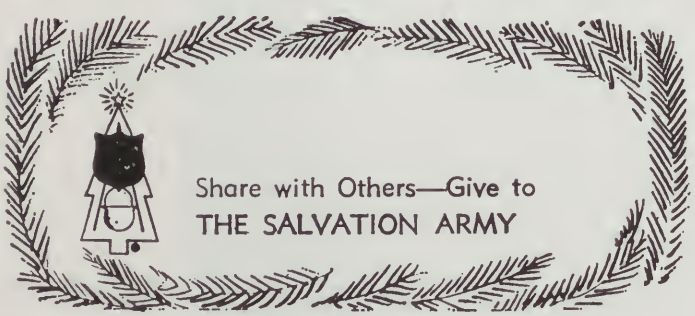
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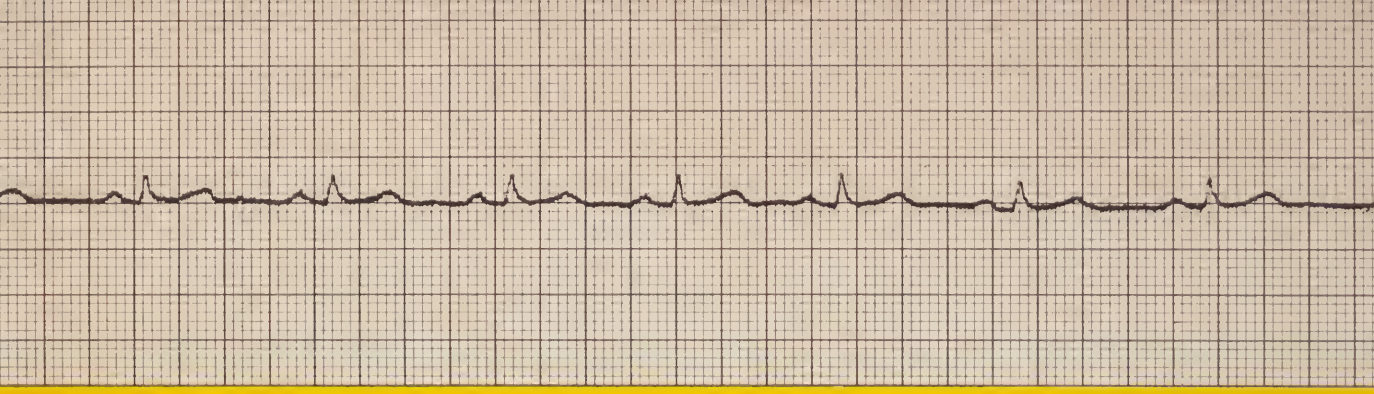
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